

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16928					16940					
1. DECEASED-NAME (Type or print) <b>Lewis Edward Adkins</b>					2a. DATE OF DEATH Month <b>Dec</b> Day <b>8</b> Year <b>68</b>			2b. HOUR <b>8:38</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 6, 1891</b>		6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b> IF UNDER 24 HRS. HOURS <b>1</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Parkton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miller Rd.</b>			12a. USUAL OCCUPATION (Kind at work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Miller Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Morgan Adkins</b>					15. MOTHER'S MAIDEN NAME, First Middle Last <b>Clantis Wright</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <b>409-28-4368</b>		17. INFORMANT <b>Mrs. Dottie Dell, Miller Rd, Parkton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the larynx</b> <b>1619</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1618</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>4/7/65</b> , to <b>12/8/68</b> , that (I) (we) last saw the deceased alive on <b>12/7/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>A.M. France M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>12/8/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>A.M. FRANCE M.D.</b>					22e. ADDRESS <b>PARKTON, Md</b>					
23a. BURIAL <del>CREMATION</del> , REMOVAL (Specify) <b>Dec. 11, 1968</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Guthrie Highland</b>		23d. LOCATION (City or Town) (County) (State) <b>Guthrie, Todd Co, Ky.</b>				
24. FUNERAL DIRECTOR <b>James J. Hartenstein, New Freedom, Pa.</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

MEDICAL CERTIFICATION

10008



*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

DEC 13 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16929					16941					
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH					
First Archer Middle A. Last Alexander					Month December Day 24, Year 1968					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR		
male		white		April 13, 1904		64 YRS.		2:30 M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U. S.				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			clerk typist		US Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		White Marsh		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		BBox 1072 R F D	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
John Alexander					Ella Kennedy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
no					705-055393		Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right cardiac failure										
492X DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emphysema										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
5271										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (X) (this hospital) attended the deceased from Oct. 21, 1959, to Dec. 24, 1968, that (X) (we) last saw the deceased alive on Dec. 24, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Diomidis Pirovolidis, M.D.									12-24-68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
					SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Dec. 27, 1968		St. Stephens Cemetery		Bradshaw Balto Md				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard K. McComas & Son, Abingdon, Md.					DEC 30 1968		Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
16942									
1. DECEASED-NAME (Type & print) <b>CHARLES</b>			First Middle Last <b>EDGAR ALLERS</b>			2a. DATE OF DEATH Month Day Year <b>Dec. 25 1968</b>		2b. HOUR <b>3:10 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 12, 1884</b>		6. AGE (In years lost birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign) <b>McDonough Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE Co.</b> Md.			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUMMIT Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>McDONOUGH SCH CO.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>11 Shenton Rd.</b>	
14. FATHER'S NAME First Middle Last <b>John Henry Allers</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lavinia Mulligan</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-16-8211</b>		17. INFORMANT <b>Mrs. Frances A. Seavitt</b>		Address <b>11 Shenton Rd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 DISEASE; CORONARY INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF <b>URINARY TRACT INFECTION</b> (b) <b>MULTIPLE DECUBITIC ULCERS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTHRITIS DEFORMANS - VERY ADVANCED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/19, 1968</b> , to <b>12/25, 1968</b> , that (I) (we) lost the deceased alive on <b>12/23/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>S. Kerson M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/25/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>E. LASARITIS, M.D.</b>		22e. ADDRESS <b>BALTIMORE, MD 21228</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville Baltimore Md</b>			
24. FUNERAL DIRECTOR <b>Frank A. Newell</b>		ADDRESS <b>Pikesville, Md.</b>		25. RECEIVED BY REGISTRAR <b>DEC 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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DEC 9 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16931

CERTIFICATE OF DEATH

16943

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
PAULINE		N.		ALT	DECEMBER 9, 1968		5:15	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
FEMALE	WHITE		OCTOBER 14, 1897		71 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
RUSSIA	USA			BALTIMORE,				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL		HOUSEWIFE		OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
MARYLAND		BALTIMORE	TOWSON		610 GOUCHER BLVD. #21204			
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle
		Dimitri	Nikitenko				Anna	Petroff
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address			
no		none		090-05-3166	Family records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastasis.</u> <u>151.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>151X</u>								
19a. DATE OF OPERATION <u>11-26-68</u> <u>12-2-68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Esophageal obstruction.</u> <u>Ca. of stomach with metastasis.</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <u>X</u> (this hospital) attended the deceased from <u>November 24, 1968</u> , to <u>December 9, 1968</u> , that <u>X</u> (we) lost saw the deceased alive on <u>December 9, 1968</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) (did) (did not) view the body after death.								
22. SIGNATURE <u>Camilo Z. Tomboc</u>				DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input checked="" type="checkbox"/> 22c. DATE SIGNED <u>December 9, 1968</u>
22d. PHYSICIAN'S NAME (Type) Camilo Tomboc, M.D.				22e. ADDRESS <u>7620 York Road Towson, Md. #21204</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial/transit</u>	<u>12/11/68</u>	<u>Hillcrest Memorial Park</u>		<u>West Palm Beach Florida</u>				
24. FUNERAL DIRECTOR ADDRESS <u>John Burns Sons 610-12 York Rd. Towson, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 11 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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30M REV. 1-68

16932		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		16944	
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Minnie		Virginia Austin Austen		Month Day Year December 15, 1968		10:45 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
female		white		Nov. 9, 1909		59 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md.		U. S.				Baltimore Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		SPRING GROVE STATE HOSP.		housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md.		Balto.		Govans		13e. STREET AND NUMBER 612 Anneslie Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
Benjamin Wilkinson		Dora V. Earle		No			
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4500		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 22, 1968, to Dec. 15, 1968, that (I) (we) last saw the deceased alive on Dec. 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE Diomidis Pirovolidis, M.D.		22c. DATE SIGNED 12-16-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
Spring Grove State Hospital		Baltimore, Maryland 21228		Burial		12-19-1968	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
Moreland Memorial		Baltimore Co. Md.		Lassahn Funeral Home 7401 Elair Road 21236		DATE DEC 23 1968	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 408 (4)  
MOR REV. 3-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First JOHN		Middle NMN		Last BACON		2a. DATE OF DEATH 12 Month 31 Day 68 Year		2b. HOUR a 2:10 M
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 3-6-1893		6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		Md.		
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GTR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chemical Analyst-ret.		12b. KIND OF BUSINESS OR INDUSTRY Wylie Chem. Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Falls Road		
14. FATHER'S NAME First Robert Bacon		Middle Lost		15. MOTHER'S MAIDEN NAME First Unknown		Middle Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service) None		16b. SOCIAL SECURITY NO. 215-05-8184		17. INFORMANT Family records		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE										
4129 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 METASTATIC CA OF PROSTATE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (X) (this hospital) attended the deceased from 11-30, 1968, to 12-31, 1968, that (X) (we) last saw the deceased alive on 12-31, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Josefino C. Aguilar		DEGREE ATTENDING PHYS.		<input type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		<input checked="" type="checkbox"/> 22c. DATE SIGNED 12-31-68		
22d. PHYSICIAN'S NAME (Type) DR. JOSEFINO C. AGUILAR		22e. ADDRESS 6701 N. CHARLES ST.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Jesson's Cemetery		23d. LOCATION (City or Town) Cockeysville, Md.		(County)		(State)
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE f Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16934  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16946

1. DECEASED-NAME (Type or print) <b>HERMAN</b>		First Middle Last		2a. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>68</b>		2b. HOUR <b>5:50</b> P.M.	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>2-4-1883</b>		6. AGE (In years last birthday) <b>85</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>BALTO.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>PARKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>9100 Smith Avenue</b>		14. FATHER'S NAME First Middle Last <b>RUDOLPH BARK</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ULMAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>420-34-7179</b>		17. INFORMANT <b>MRS. HERMAN BARK 9100 SMITH AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease; Cong. Heart Failure</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF <b>4200</b> (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-24-</b> , 19 <b>68</b> , to <b>12-24-</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-24-</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>xilia C. Baldonado</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, READY (Specify)		23b. DATE <b>12-28-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Belair Mem. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Belair Md.</b>	
24. FUNERAL DIRECTOR <b>Lessahy H 7401 Belair Rd.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

16935

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16947

1. DECEASED-NAME (Type or print) <b>WILLIAM J. BATCHLER</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1968</b>			2b. HOUR M			
3. SEX <b>male</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH <b>December 27, 1889.</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chesapeake Manor Nurs. Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Electrical Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4516 N. Charles St.</b>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>041-05-7836</b>		17. INFORMANT <b>Mrs. Flo B. Batchler</b>		Address <b>(Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circumferential Aortic Aneurysm</b> <b>185X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6-7 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>177X Atherosclerotic Heart Disease. Cardiac Failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>53</b> , to <b>12/17</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sylvan D. Goldberg, M.D.</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/19/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Dr. Sylvan D. Goldberg</b>		22e. ADDRESS <b>Medical Arts Bldg, Balto, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/20/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Pk. Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. - Balto, Md. - 14</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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W. V. Charles

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16936

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16948

1. DECEASED-NAME (Type or Print) <b>FREDERICK C. BAUER</b>			2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>5/24/02</b>	6. AGE (In years last birthday) <b>66 YRS.</b>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		7c. COUNTY OF DEATH <b>BALTO.</b>
10. CITY OR TOWN OF DEATH <b>ESSEX</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1420 SHORE RD.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FOREMAN</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>ESSEX</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>			15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>			16b. SOCIAL SECURITY NO. <b>212-03-4651</b>	17. INFORMANT ADDRESS <b>ALMA BAUER ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HCUP</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19 <input type="checkbox"/>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Theo C. Patterson</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12/19/68</b>
EXAMINER'S NAME (Type) <b>THEO. C. PATTERSON</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12/19/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>			ADDRESS <b>300 MACE</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1968</b>
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

FOR AUNT  
HEAVEN LIST

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DEATH LISTING / RECORD OF DEATH

DEC 1 1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154  
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16937					16949					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
First Middle Last Joseph (Guiseippe) Bavota					Month Day Year December 31, 1968		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male		White		April 16, 1877		91 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Italy		U. S. A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Dundalk			851 Jaydee Avenue			Self-employed Shoemaker				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		851 Jaydee Ave.	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Joseph Bavota					??					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Son) Address					
No			217-16-6170		Roland Bavota, 206 Parkwood Rd. Dundalk, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion									1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-Sclerosis									5 years	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 8/1/60, 19 60, to 12/30, 19 68, that (I) (we) last saw the deceased alive on 12/30, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Dec 31-1968-2 PM										
22b. SIGNATURE Morris A. Jacobs M.D.					22c. DATE SIGNED 1/2/69		22d. ADDRESS 1010 North Point Rd. Dundalk, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1/4/69		Gardens of Faith Cemetery			Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.					25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16950

1. DECEASED-NAME (Type or print) First Middle Last <b>JAMES FREDERICK BAZEMORE</b>			2a. DATE OF DEATH Month Day Year <b>DECEMBER 23, 1968</b>		2b. HOUR Min <b>4:30p</b>
3. SEX <b>MALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH <b>2/10/23</b>		6. AGE (In years last birthday) <b>45</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE,</b> Md.		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMIN. HOSPITAL</b>	12a. USUAL OCCUPATION (Kind of work done during and immediately before death, even if retired.) <b>MAINTENANCE</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1419 CHESAPEAKE CT.</b>	
14. FATHER'S NAME First Middle Last <b>RUFUS - - BAZEMORE</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>ETHEL - - HOLMES</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>YES WWII</b>	16b. SOCIAL SECURITY NO. <b>579 18 10 98</b>	17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL HEMORRHAGE</b> <b>5699</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>578X</b> (b) <b>ACUTE RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>BRONCHOPNEUMONIA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no autopsy</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <del>to</del> (this hospital) attended the deceased from <b>DEC 13</b> , 19 <b>68</b> , to <b>DEC 23</b> , 19 <b>68</b> , that <del>it</del> (we) lost the deceased on <b>DEC 23</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) <del>not</del> view the body after death.					
22b. SIGNATURE <i>J. D. Talbert M.D.</i>					22c. DATE SIGNED <b>12/24/68</b>
22d. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>					22e. ADDRESS <b>VAH, FT. HOWARD, MD.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-28-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Md.</b>		
24. FUNERAL DIRECTOR <i>Philip J. Kay</i>		25a. RECORDING OFFICE <b>BARNES AND MATTHEWS FUNERAL HOME</b> 3619 14th St. N.W. Baltimore, Md.		25b. REGISTRATION <b>DEC 20 1968</b> <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16939		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		16951	
1. DECEASED-NAME (Type or print) <b>HARRY</b>		First		Middle		Last	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>April 11, 1881</b>		20. DATE OF DEATH Month <b>12</b> Day <b>3</b> Year <b>68</b>	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (In years lost birthday) <b>87</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7800 Rolling View Ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARM WORK</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>Fullerton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>Unknown</b>		15. MOTHER'S MAIDEN NAME <b>Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ross Fitch</b>		Address <b>7800 Rolling View Ave BALTO.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163x Arteriosclerosis, generalized</b>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22c. DATE SIGNED <b>Dec. 4, 1968</b>	
22a. SIGNATURE <b>Adam G. Swiss M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. PHYSICIAN'S NAME (Type) <b>Adam G. Swiss</b>	
22e. ADDRESS <b>6232 Belair Rd. Balto., Md 21206</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>	
23d. LOCATION (City or Town) (County) (State) <b>Parkville, Balt</b>		24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Rd. Balto. 36</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 6 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		VR A15 (1)		30M REV. 11/68			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>16940</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>16952</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>																	
1. DECEASED-NAME (Type or print) <b>GEORGE</b>				First <b>A.</b> Middle <b>A.</b> Last <b>BELL</b>				2a. DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>68</b>				2b. HOUR <b>12:00</b>					
3. SEX <b>MALE</b>				4. RACE <b>NEGRO</b>				5. DATE OF BIRTH <b>3/6/96</b>				6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md.					
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DET. ADM. HOSP. FT HOWARD, MD.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PAINTER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>WICOMICO</b>				13c. CITY OR TOWN <b>SALISBURY</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>102 SECOND STREET</b>			
14. FATHER'S NAME First <b>ALFRED</b> Middle <b>BELL</b> Last <b>BELL</b>				15. MOTHER'S MAIDEN NAME First <b>HETTIE</b> Middle <b>DAVIS</b> Last <b>DAVIS</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give war and dates of service) <b>WW I</b>				16b. SOCIAL SECURITY NO. <b>216 14 20 79</b>				17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>4389</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY CONGESTION AND EDEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIFFUSE CEREBRAL EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>334 X</b>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (a) (this hospital) attended the deceased from <b>12/13/68</b> , 19____, to <b>12/17/1968</b> 19____, that (b) (we) last saw the deceased alive on <b>12/17/68</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (do not) view the body after death.																	
22b. SIGNATURE <i>Peter V. Juvan</i>												DEGREE <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/17/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>												22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>12/22/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>GREEN ACRES CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>SALISBURY, MARYLAND</b>					
24. FUNERAL DIRECTOR <i>Clinton F. Stewart</i>												ADDRESS <b>CLINTON STEWART FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>	
CITY <b>SALISBURY, MARYLAND</b>																	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

169411

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16953

1. DECEASED-NAME (Type or Print) <b>James N Bennett</b>			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year <b>12 21 1968</b>			2b. HOUR OF DEATH ESTI- MATED <b>12:30 PM</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>12/27/13</b>	6. AGE (In years last birthday) <b>54</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>21</b> Year <b>1968</b>			2d. HOUR <b>p</b>
7a. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore County</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore County General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Maintenance mech.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Schenuit</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 1</b>
14. FATHER'S NAME First <b>Urey</b> Middle <b>Bennett</b> Last <b>Bennett</b>			15. MOTHER'S MAIDEN NAME First <b>Anthela</b> Middle <b>Hammond</b> Last <b>Hammond</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>36-10-2077</b>		17. INFORMANT <b>Mr. Lelew, 97 Ridge Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>arrhythmia</b> <b>Arterio-sclerotic Cardiovascular Disease</b> (c) <b>6 months</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Slipped disc.</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>J. Nelson McKay</b>			M.D. <b>J. Nelson McKay, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12/21/68</b>	
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		23d. LOCATION (City or Town) (County) (State) <b>Tioga, Nicholas, W. Va.</b>			
24. FUNERAL DIRECTOR <b>Edwin L. Molesworth</b>				ADDRESS <b>Molesworth Funeral Home, Damascus, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

10438

10438

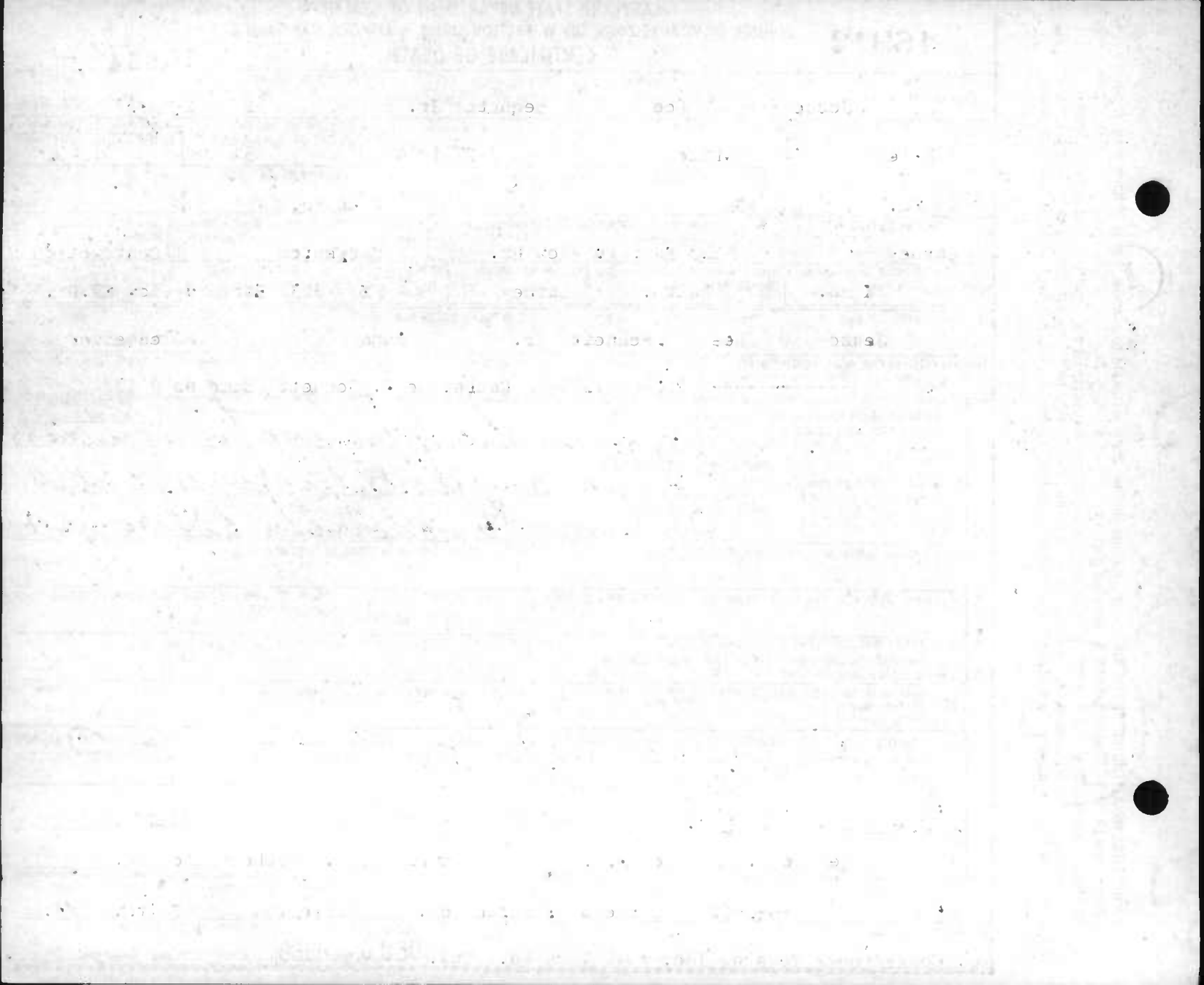
10438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-14  
30M REV. 1-68

16942										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16954									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Jesse Lee Bennett, Jr.										Month 12 Day 2 Year 1968										12:15A M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Male			White			9-21-1914			54 YRS.			MONTHS DAYS HOURS MIN.																	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Md.			USA						Balto. Md.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Carney					9233 Harford View Dr.					Carpenter					Construction														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
X Md.					Balto.					Carney					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					9233 Harford View Dr.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					Address																			
Jesse Lee Bennett, Sr.					Anna Adlesberger																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT																			
NO					218-01-1399					Catherine W. Bennett Same as # 13																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) myocardial infarction															30 min														
7123 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
(b) Coronary atherosclerosis															6 yrs.														
DUE TO, OR AS A CONSEQUENCE OF																													
(c) Rheumatic valvulitis															20 yrs.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
7220																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION																			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from July 1956, to Dec 1968, that (I) (we) last saw the deceased alive on Nov 6 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE															22c. DATE SIGNED														
George T. Gilmore M.D.															XXXXX 12-2-1968														
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS														
George T. Gilmore, M.D.															Lanham Bldg., Lutherville, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12-4-1968					Gardens of Faith Cem.					Fullerton Balto. Md.														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Wm. Cook-Brooks Towson, Inc. 1050 York Rd., Tow										DEC 5 1968										Charles J. Jago									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
<div style="display: flex; justify-content: space-between;"> <span>16943</span> <span>17 F4lmG408 1/3/69 kk</span> <span>CERTIFICATE OF DEATH</span> </div>															
1. DECEASED-NAME (Type or print)						First			Middle			Last			
Charles						Bantz									
3. SEX						4. RACE			5. DATE OF BIRTH			2a. DATE OF DEATH			
Male						White			Mar. 3, 1885			Month 12 Day 23 Year 68 7: P. M.			
7a. BIRTHPLACE (State or foreign country)						7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Md.						U.S.A.						Balto.			
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville Md.						Paradise Nursing Home			Retired						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Md.						Balto.			Catonsville			YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last									
George Bantz						Elizabeth Schultz									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)						16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
Yes, no, or unknown						215-07-5513			Mrs. Helen M. Piccione			921 Masfield Rd. Balto. Md. 21201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>												4 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>thrombotic arteriosclerosis</u>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
4200 <u>psoriasis</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>10-11-54</u> 19 <u>68</u> , to <u>12-23-68</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-23-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>HARRY S. GUMBEL</u> MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															
22c. DATE SIGNED <u>12-24-68</u>															
22d. PHYSICIAN'S NAME (Type) <u>HARRY S. GUMBEL</u> 22e. ADDRESS <u>4605 Edmonson Ave</u>															
23a. BURIAL, CREMATION, or other disposition (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				12/26/1968				New Cathedral Cemetery				Baltimore Maryland			
24. FUNERAL DIRECTOR H. H. Witzke & Sons 4101 Edmondson Ave. ADDRESS															
25a. REC'D BY REGISTRAR DEC 27 1968															
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>															



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <b>THEODORE</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>Dec. 8, 1968</b>			2b. HOUR <b>1:08A</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8-17-1908</b>		6. AGE (In years last birthday) <b>60 YRS.</b>		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) <b>NEW YORK, N.Y.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rte 40 West Korvette Store Parking Lot</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>EMPLOYEE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>KORVETTE</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>3703 Fallstaff Road</b>	
14. FATHER'S NAME <b>JACOB</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>YETTA</b>			First Middle Last <b>?</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>035-05-0113</b>			17. INFORMANT ADDRESS <b>MRS. MARTHA BERKOWITZ, 3703 FALLSTAFF RD., APT. 1</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4129</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>December 8, 1968</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12-9-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OH R KNESSETH ISRAEL ANSHE SFARD, ROSEDALE, MARYLAND</b>			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>						25a. REC'D BY REGISTRAR <b>DEC 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

0001 01 030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16945										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16957																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
DR. HAROLD										HANS										BIX										DECEMBER 23 1968										30 A.M.																			
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
MALE										WHITE										APRIL 20, 1897										71 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
WINNERA										U.S.A.																				BALTIMORE																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
BALTIMORE										6815 TIMBERLANE ROAD										PHYSICIAN										CARDIOLOGIST																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										BALTIMORE																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										6815 TIMBERLANE ROAD																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
DR. ELIAS										BIX										ADELE										BIX																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
NO										220-46-5047										MRS. ELIZABETH BIX										6815 TIMBERLANE ROAD																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										4129										Widespread C.V.D.										2 yr																													
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
																				(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																																																											
4221																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Jan 1955, to Dec 23 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																													
22d. PHYSICIAN'S NAME (Type)										JOSEPH GROSS										22e. ADDRESS										6911 PARK HEIGHTS AVENUE																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										12-25-68										CHIZUK AMANO (ARLINGTON)										BALTIMORE, MARYLAND																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
SOL LEVINSON & BROS.,										6010 REISTERSTOWN ROAD										DATE DEC 30 1968										J Charles Judge																													

1953

CONFIDENTIAL

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CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

DEC 30 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)  
30M REV. 1/68

MIDDLE									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>DORIS NACE LENA BLACK</b>					2a. DATE OF DEATH <b>DEC. 2 Day 1968</b>			2b. HOUR <b>1:20</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH <b>5/12/1909</b>			6. AGE (In years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore, Md.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Baltimore</b>			13b. COUNTY <b>City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4618 Marble Hall 21212</b>		
14. FATHER'S NAME First Middle Last <b>Roland Nace</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Leonora Briggs</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service) <b>---</b>			16b. SOCIAL SECURITY NO. <b>216-44-2917</b>		17. INFORMANT Address <b>21214 Edward A. Briggs (Uncle) 6300 Burchwood Ave</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bone marrow depression</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Radiation therapy with gastro-intestinal</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hemorrhage and urinary tract hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>170X History of carcinoma of right breast</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/31, 1968</b> , to <b>12/2, 1968</b> , that (I) (we) last saw the deceased alive on <b>12/2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>ER Sowden</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/2/68</b>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/5/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Eugenia K. Seitz 5209 York Road Balto. Md. 21212</b>					25a. REC'D BY REGISTRAR <b>DEC 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16917					16959						
1. DECEASED-NAME (Type or print) <b>Marian Louise Bogia</b>					2a. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>68</b>			2b. HOUR <b>8.10</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-1-09</b>			6. AGE (In years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>508 Brook Rd, 21204</b>		
14. FATHER'S NAME First <b>Robert</b> Middle <b>Scarborough</b> Last <b>Griffith</b>					15. MOTHER'S MAIDEN NAME First <b>Rachael</b> Middle <b>Griffith</b> Last <b>Griffith</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>220-32-2870</b>		17. INFORMANT <b>Roland A. Bogia</b>			Address <b>(Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Broncho Pneumonia</b> <b>485 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>491 X</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>12-17-</b> , 19 <b>68</b> , to <b>12-21</b> , 19 <b>68</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>12-21-</b> 19 <b>68</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Samuel C. Lee M.D.</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12-21-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Samuel C. Lee M.D.</b>					22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto.Co., Md.</b>				
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>1905 York Rd. Balto. 12, Md.</b>					25a. REC'D BY REGISTRAR <b>DEC 24 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

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INDICATOR OF ORIGIN



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

16948				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16960							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year				2b. HOUR	
T. THOMAS								BRACKEN		12/26/1968				1025AM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE		9/11/1899				69 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH									
England		USA (?)		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore County,						Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
Mount Wilson		Mt. Wilson St. Hosp.		Printer											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
MD		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5104 Palmer Ave.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
Thomas		Claire Townsend		NO		143-05-7726		Richard T. Bracken-104 Hilton Ave 21228 Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4129 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonitis, Bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4200</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 mos.</u> <u>3 days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pulmonary Emphysema</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>12/23/1968</u> , to <u>12/26/1968</u> , that (I) (we) last saw the deceased alive on <u>12/26/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
<u>W. Newcomer</u>		<u>12/26/68</u>		William Newcomer, M.D.		Mount Wilson, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)									
Burial		12-28-68		Woodlawn Cemetery		Baltimore, Maryland									
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE									
W. Ellsworth Armacost-4600 Liberty Hgts. Ave		DEC 31 1968		J. Charles Judge											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16949										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16961																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR P																																							
First Middle Last										12 Month 10 Day 68 Year										6:50 M																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Male										Caucasian										9/10/1906										62 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
BALTO.																														Baltimore										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																													
Towson										Greater Balto. Med. Center										Retired																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Md										Balto										Towson										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										1840 EDGEWOOD RO																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
CHARLES F										216-44-6711										SOPHIA L. HANSON																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO. (If yes give war or dates of service)										17. INFORMANT Address																																							
NO										216-44-6711										WIFE										SAME																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										Acute myelogenous leukemia																																																	
2050										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)																																																	
										DUE TO, OR AS A CONSEQUENCE OF																																																	
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																																																											
2043																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 11/9, 19 68, to 12/10, 19 68, that (I) (we) lost saw the deceased alive on 12/10, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12/11/68																													
22d. PHYSICIAN'S NAME (Type)										Rudiger Breiteneker, M.D.										22e. ADDRESS 6701 North Charles Street																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 12/16/68										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Baltimore																				Baltimore																																							
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR DATE										25b. REGISTRAR'S SIGNATURE																													
Ch. Seeman										6062 Hay Rd										DEC 16 1968										J. Charles Judge																													

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## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Rosalie O. Brandt</i>			First Middle Last			2a. DATE OF DEATH Month <i>12</i> Day <i>15</i> Year <i>68</i>			2b. HOUR <i>6:15 PM</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>11/5/1886</i>			6. AGE (In years last birthday) <i>82</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Altoona Pa.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i> Md.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Grey Hall Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institutional. Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>PA</i>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <i>Lustig Baum</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna Hamman</i>			13e. STREET AND NUMBER <i>1806 Old Joppa Rd.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>unknown</i>			17. INFORMANT <i>Thomas A. Brandt</i>			Address <i>1806 Old Joppa Road</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocardial failure</i> <i>4129</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis Cardiovascular</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>1 wk</i> <i>2 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> , 19 <i>68</i> , to <i>12/15</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J.M. Baumgardner</i>									22c. DATE SIGNED <i>12/16/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Balto 21237</i>									22e. ADDRESS <i>Balto 21237</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>12/18/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Altoona Pa.</i>		
24. FUNERAL DIRECTOR <i>John A. Moran, Inc. 3000 E. Balto. St.</i>						25a. REC'D BY REGISTRAR DATE <i>DEC 20 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16951 CERTIFICATE OF DEATH 16963

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulany Towson NAC Home 111 West Rd</u>		d. STREET ADDRESS <u>7111 Campfield Road 21207</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First Middle Last <u>XXXXXX</u> <u>Earl</u> <u>BRAY</u>		4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1968</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1905</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>21</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitary Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James Terry Bray</u>		14. MOTHER'S MAIDEN NAME <u>Edna Morrow Bray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-2554</u>	
17. INFORMANT <u>Mildred Bray</u>		Address <u>7111 Campfield Road 21207</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> <u>185X</u> DUE TO (b) <u>C of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertensive CVD</u> DUE TO (c) <u>177X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Secondary Arterio Sclerotic</u> <u>Renal changes</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>63</u> to <u>12-21</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-20</u> 19 <u>68</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas G Abbott</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thomas G Abbott</u>		22d. ADDRESS <u>4509 Liberty Heights Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-24-68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		25c. ADDRESS <u>4600 Liberty Hgts. Ave</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16952

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16964

1. DECEASED-NAME (Type or print)		First Lillian	Middle P.	Last Bristow	2a. DATE OF DEATH Month Day Year December 20, 1968		2b. HOUR 1:15 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4-30-1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5703 Carter Avenue #21214	
14. FATHER'S NAME First Middle Last Robert Applegarth		15. MOTHER'S MAIDEN NAME First Middle Last Nannie Phillips		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 024-03-7025D		17. INFORMANT Address Mr Thomas B Gier Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable pulmonary embolism with history of</u> <u>4109</u> <u>myocardial infarction.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>November 27, 1968</u> , to <u>December 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Lilia C. Baldonado</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED December 20, 1968	
22d. PHYSICIAN'S NAME (Type) Lilia Baldonado, M.D.				22e. ADDRESS 7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/24/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Baltimore, Maryland				25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16953

CERTIFICATE OF DEATH

16965

1. DECEASED-NAME (Type or print) <b>Raymond Hayse Bristow</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>12</b> Year <b>68</b>			2b. HOUR <b>M</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 10, 1905</b>		6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA-St Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Self Employed</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Delicatessen</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6933 Harford Rd</b>		
14. FATHER'S NAME First <b>Raymond</b> Middle <b>J</b> Last <b>Bristow</b>			15. MOTHER'S MAIDEN NAME First <b>Blanche</b> Middle <b>Lewis</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>216-01-9706</b>		17. INFORMANT <b>Mrs Alma A Bristow</b>			Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 yrs</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/29</b> , 19 <b>63</b> , to <b>12/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. M. Baumgardner</b> DEGREE <b>M.D.</b>						22c. DATE SIGNED <b>12/12/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>G. M. Baumgardner M.D.</b>						22e. ADDRESS <b>8552 Philadelphia Rd Baltimore, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/16/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>						25a. RECEIVED BY REGISTRAR DATE <b>DEC 13 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

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Item 13e Film G408 1/10/69 ts

CERTIFICATE OF DEATH

16966

1. DECEASED-NAME (Type or print) <b>Lottie Carroll Brooks</b>			2a. DATE OF DEATH <b>12</b> Month <b>27</b> Day <b>68</b> Year		2b. HOUR <b>6:45</b> PM
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9-30-1883</b>		6. AGE (In years last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore County</b> Md.		
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. County Gen. Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Chapel Hill Conv. Home 6900 Lachlan Circle</b>
14. FATHER'S NAME First Middle Last <b>Thomas Mason</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Laura Hudgins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>N/O</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Dorothy H. Conson 6700 Lachlan Cr. Balt. Md. 21212</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-23, 1968</b> , to <b>12-27, 1968</b> , that (I) (we) last saw the deceased alive on <b>12-27, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Angela Spina</b>				DEGREE <b>ANGELITA TOPANO</b>	22c. DATE SIGNED <b>12-27-68</b>
22d. PHYSICIAN'S NAME (Type) <b>ANGELITA TOPANO</b>		22e. ADDRESS <b>BOBA</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/31/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Balt. Co. Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks West Inc</b>			25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10/10/10 11/11/10

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APR 8 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 1-73

16955				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16967			
1				CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
IDA						BROTHERS		DECEMBER 25, 1968		1:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		12-25-1902		66 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
BALTIMORE, MD.		U.S.A.				BALTIMORE					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		6984 MILBROOK PK. DR., APT. 1C		HOUSEWIFE		AT HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		BALTIMORE						6984 MILBROOK PK. DR., APT. 1C			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
JACOB WEINSTEIN								SARAH		FISHBEIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		212-36-3252		MR. SEYMOUR BROTHERS,		5505 RUSK AVENUE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4109				Acute hyperacute Infection							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		ASCUD					
		(c)		DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		4201		Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 1965, to _____, 1968, that (I) (we) last saw the deceased alive on _____, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		LEONARD GOLOBEK		22e. ADDRESS		7039 LIBERTY ROAD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		12-27-68		SHAAREI TFILOH		BALTIMORE, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SOL LEVINSON & BROS.,		6010 REISTERSTOWN ROAD		DEC 30 1968		Charles Judge					

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JACOB REINSTEIN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1 2  
16956  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
16968

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gradshaw</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gradshaw</u>	
c. LENGTH OF STAY IN 1b <u>50 yrs</u>		d. STREET ADDRESS <u>Pfeffers Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pfeffers Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>W.</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1968</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Kinder</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Margaret Johnson, Perry Hall, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arterial sclerosis heart disease with</u> DUE TO (c) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>50</u> , to <u>Dec 1</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 1</u> 19 <u>68</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Fred O. Hodous</u>		22b. DATE SIGNED <u>12-1-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Fred O. Hodous</u>		22d. ADDRESS <u>Edgewood md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/5/68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury M. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>White Marsh Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Chetman</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1701 N. Calhoun St. Balto. Md.</u>		DATE <u>DEC 9 1968</u>	

17888

CLINICAL OF DEATH

1888

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16957

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16969

1. DECEASED-NAME (Type or Print)		First GENE		Middle B.		Last BRUNS		20. DATE KNOWN OF DEATH ESTIMATED December 31, 1968		2b. HOUR PM	
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH 12-15-1911	6. AGE (In years last birthday) 57	7. YRS. 57	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	21. DATE PRONOUNCED DEAD December 31, 1968		2d. HOUR PM		
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Baltimore 21212			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 207 N. Tyrone Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore 21212		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e. STREET AND NUMBER 207 N. Tyrone Road			
14. FATHER'S NAME First Middle Last Robert S. Brown				15. MOTHER'S MAIDEN NAME First Middle Last Mary				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16b. SOCIAL SECURITY NO.				17. INFORMANT John J. Bruns, Jr.,				ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 1/31/68			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		23d. LOCATION (City or Town) (County) (State) Waynesboro. Penna.					
24. FUNERAL DIRECTOR Wm. Cook-Brooks						ADDRESS Towson, 1050 York Rd., Towson, Md.		25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

18863

UNITED STATES DEPARTMENT OF THE INTERIOR

MINERAL LANDS DIVISION

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FOR SALE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div>16958</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item#8Film#G408 12/31/68 vmp</div> <div>CERTIFICATE OF DEATH</div> <div>16970</div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
NAN			BRUNZELL			Month 12 Day 20 Year 68			11A. M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
F.		W		7/182			86 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
United States		U.S.				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE			SHANGRI-LA N.H.			HOUSE WIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
22d			Catonville					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		58 N. Rogers Ave.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
S. Thompson Corn				Emma B. Corn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
no					Mrs. Carl Carlson, 58 N. Rogers Ave. 21203						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pulmonary Embolism										Acute	
4519 DUE TO, OR AS A CONSEQUENCE OF											
(b) Pile both thrombosis										Days	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Approximate Interval Between Onset and Death	
ASCVD - Fracture L. Hip old - Cataracts - Kyphosis Marked											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 8-31-1968, to 12-20-1968, that (I) (we) last saw the deceased alive on 12-20-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Cesar Valle Cervero								DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-20-68	
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO								22e. ADDRESS 8629 Liberty Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		12/23/68		Sam Houston National		Ft. Sam, Texas					
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry H. Witzke, Ellicott City, Md. 21043						25a. REC'D BY REGISTRAR DATE DEC 23 1968		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16959

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16971

1. DECEASED-NAME (Type or print) First MARY Middle ELIZABETH Last BUCHANNON			2a. DATE OF DEATH Month 12 Day 9 Year 1968		2b. HOUR 9A M
3. SEX FEMALE		4. RACE COLORED		5. DATE OF BIRTH 12-28-03	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH BALTIMORE			12b. KIND OF BUSINESS OR INDUSTRY Housewife		
10. CITY OR TOWN OF DEATH GLENARM		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Maryland Box 217-Glenarm,		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. STREET AND NUMBER Box 217-Glenarm, Md.	
14. FATHER'S NAME First Ernest Middle Walker Last Walker		15. MOTHER'S MAIDEN NAME First Daisy Middle Jackson Last Jackson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 214-18-5681		17. INFORMANT Charles Buchar <del>WDA</del> Box 217 Glenarm, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 492X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Embolism</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 da 3 da 10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 527.1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Dec.</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Nov-26</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>S. E. Harris</u>				22c. DATE SIGNED 12/2/68	
22d. PHYSICIAN'S NAME (Type) Dr. S. E. HARRIS				22e. ADDRESS 8100 Harford Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-5-1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR Marshall W. Jones, Jr. 1735 Harford Ave.			
25a. REC'D BY REGISTRAR DATE DEC 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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RECEIVED

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 11 Film 407 12/13/68  
16960

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16972

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>ALBERT S. BUMGARNER DDS</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>5th</b> Year <b>1968</b>			2b. HOUR <b>9:30</b> <sup>A</sup>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 7th, 1902</b>		6. AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Balto. City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED- <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Monkton, Balto. Co.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Old York Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Dentist (ret.)</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Monkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Old York Road</b>		
14. FATHER'S NAME First Middle Last <b>Albert L. Bumgarner</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Pauline McCless</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>yes</b> (If yes give war or dates of service) <b>WW-1</b>				16b. SOCIAL SECURITY NO. <b>220-44-2425</b>		17. INFORMANT Address <b>Mrs. Lovisah N. Bumgarner-Old York Rd, Monkton</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio-sclerotic cardio vascular disease</b> <b>yes</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-6</b> , 19 <b>66</b> , to <b>12-5</b> , 19 <b>68</b> , that (I) ( <b>we</b> ) last saw the deceased alive on <b>Sept 16</b> , 19 <b>68</b> , and that in (my) ( <b>our</b> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <b>we</b> ) ( <b>did</b> ) (did not) view the body after death.											
22b. SIGNATURE <b>Alfred G. Ossman</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-6-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Alfred G. Ossman M.D.</b>						22e. ADDRESS <b>1101 St. Paul Street-Balto.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. James Church Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Monkton, Balto. Co.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

1987

DATE OF BIRTH

1987

ALBERT J. BRYAN

June 20, 1908

White

Old York Road

Albany, New York

Albany, New York

Albany, New York

Albany, New York

Albany, New York

Albany, New York

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and return them to the State Department of Health. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16961

CERTIFICATE OF DEATH

18525

1. DECEASED-NAME (Type or print)		First Dawn	Middle Michelle	Last Burall	2a. DATE OF DEATH Month Day Year December 7, 1968		2b. HOUR 10:09		
3. SEX Female		4. RACE White		5. DATE OF BIRTH December 4, 1968		6. AGE (In years lost birthday) — YRS.		IF UNDER 1 YEAR MONTHS DAYS 3	IF UNDER 24 HRS. HOURS MIN —
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6880 McClean Blvd.	
14. FATHER'S NAME First Middle Last Bryan Nicholas Burall		15. MOTHER'S MAIDEN NAME First Middle Last Patricia Garland Winterling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>PEAXX</del> Immaturity 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from 12-4-1968, to 12-7-1968, that (X) (we) last saw the deceased alive on December 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Samuel C. H. Lee, M.D.		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-9-68			
22d. PHYSICIAN'S NAME (Type) Samuel C. H. Lee, M.D.		22e. ADDRESS 7620 York Road, Towson, Md. 21204							
23a. BURIAL (CREMATION REMOVAL (Specify)) 1-24 Egg		23b. DATE 1-24-69		23c. NAME OF CEMETERY OR CREMATORY O. J. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR JAN 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

VR 45M (4)  
45M - 1/69

81-32234

1955

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

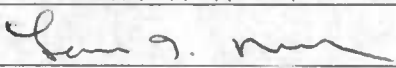

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

169932

16973

1. DECEASED-NAME (Type or print) <b>Jeffrey Michael BURALL</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>1968</b>			2b. HOUR <b>8<sup>20</sup> A M</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12/4/68</b>		6. AGE (In years last birthday) <b>NewbornRS.</b>		IF UNDER 1 YEAR MONTHS <b>9</b> DAYS <b>43</b>		IF UNDER 24 HRS HOURS <b>9</b> MIN. <b>43</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore,</b> Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>N/A</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6880 McClean Blvd.</b>		
14. FATHER'S NAME First <b>Bryan</b> Middle <b>Burall</b> Last <b>Burall</b>			15. MOTHER'S MAIDEN NAME First <b>Patricia</b> Middle <b>Garland</b> Last <b>Winterling</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>777X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>776X</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/4/</b> , 19 <b>68</b> , to <b>12/5/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/5/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12/6/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>						22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE <b>12-6-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. School</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE <b>DEC 16 1968</b>			25b. REGISTRAR'S SIGNATURE 		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15  
30M REV. 7-68

16963				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16974			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR		2c. MIN.			
RICHARD P BURK				DEC. Month 19 Day 68 Year		2:00		A		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		Caucasian		7-15-1897		71 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		GR. BALTO. MED. CENTER									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Baltimore						Blenheim Rd. Phoenix, Md.			
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last					
Andrew Burk				Katherine Trapp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				218-34-1620 A		Mrs. Lucille Burk		Blenheim Rd. Phoenix, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4129 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
				12-14, 19 68, to 12-19, 19 68							
22a. I certify that (I) (this hospital) attended the deceased from 12-14, 19 68, to 12-19, 19 68, that (I) (we) last saw the deceased alive on 12-19, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		D.G. Carolis MD		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		12-19-68	
22d. PHYSICIAN'S NAME (Type)		D.G. CARALIS, MD.		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		12-21-1968		St. John's Blenheim		Phoenix, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. Cook Brooks Towson		1630 York Rd Towson, Md.		DEC 23 1968		Charles Judge					

19072

CONFIDENTIAL

7-7-77

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Susanna O.			Middle Burlage			Last Burlage		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4-27-1935		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Calvert County, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson 4				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Shoe Machine Operator	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2925 Berwick Avenue #34	
14. FATHER'S NAME David Oeden			First Middle Last			15. MOTHER'S MAIDEN NAME Flavilla ?			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. 217-22-5734		17. INFORMANT Mrs Catherine DiStefano			ADDRESS 2925 BERWICK AVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 884X DUE TO, OR AS A CONSEQUENCE OF Fractured Left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 Hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9020 Generalized Arteriosclerosis											
19a. DATE OF OPERATION 12-14-68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of Left Hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 12/11/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell out of Bed.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. 2925 Berwick Ave		City or Town Baltimore		County Md		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 12/21/68			
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-26-1968		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer				23d. LOCATION (City or Town) BALTO.		(County) (State) Md.	
24. FUNERAL DIRECTOR J Walter Coulter 5444 BELAIR RD.						25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

15875

UNITED STATES DEPARTMENT OF AGRICULTURE

15875

UNITED STATES  
DEPARTMENT OF AGRICULTURE



DEC 30 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16965

16976

1. DECEASED-NAME (Type or print) First Middle Last <b>JOHN ALFRED BUTCHER</b>			2a. DATE OF DEATH 12 Month 28 Day 68 Year		2b. HOUR 2:15 PM
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>6/12/1922</b>		6. AGE (In years last birthday) <b>46</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE Co.</b> Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CEN.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Self Employed</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Grocer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>456 Ilchester Ave</b>	
14. FATHER'S NAME First Middle Last <b>George P. Butcher</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Barbara Boehlin</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>215-12-8063</b>	17. INFORMANT Address <b>Margaret M. Butcher Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EXTENSIVE LIVER METASTASIS</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA of RIGHT LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>163X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-10</b> , 19 <b>68</b> , to <b>12-28</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>December 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R. Rudiger Breitenedker</i>			22c. DATE SIGNED <b>12-29-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. Rudiger Breitenedker M.D.</b>			22e. ADDRESS <b>16701 N. Charles St. 21204</b>		
23a. BURIAL, CREMATION, REINTERMENT <b>Burial</b>		23b. DATE <b>1/2/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>			25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16986					16977				
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>JAMES NORMAN BYRD</b>					2a. DATE OF DEATH 12 Month 6 Day 68 Year			2b. HOUR A 2:00 PM	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11-12-90</b>		6. AGE (In years lost birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Crisfield Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GRTR. BALTO. MED. CNTR.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Mgr. Asphalt Div.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Stan. Oil</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5211 Putney Way-12</b>	
14. FATHER'S NAME First Middle Last <b>John F. Byrd</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Thornton</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or, unknown) (If yes give war or dates of service) <b>no</b>		16b. SOCIAL SECURITY NO. <b>092-07-4558</b>		17. INFORMANT Address <b>Mrs. Elsie T. Byrd-5211 Putney Way Balto.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>163x</b> (b) <b>COR. PULMONALE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CA OF LUNGS, LEFT EFFUSION</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>POSSIBLE ADRENAL CRISIS</b>									
19a. DATE OF OPERATION <b>12-5-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FLUID IN LUNGS</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-20</b> , 19 <b>68</b> , to <b>12-6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-6</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-6-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>J.C. AGUILAR</b>					22e. ADDRESS <b>6701 N. CHARLES STREET</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto.</b>			
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>					25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 10 Film 4107  
12/18/68 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
16978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>Clarence M. Calp</b>			20. DATE KNOWN OF DEATH ESTI- MATED <b>December 6, 1968</b>			2b. HOUR <b>7:15</b> M			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>12/14/05</b>	6. AGE (In years last birthday) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>December</b> Day <b>6</b> Year <b>1968</b>			
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto. co.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hillendale Contry Club</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>#11</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>808 Powers St.</b>	
14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>			15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>213-03-6762</b>		17. INFORMANT <b>Elsie L. Calp</b>		ADDRESS <b>808 Powers St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100</b> <b>Coronary Occlusion Sudden</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cardio Renal/Vascular Disease Syst</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>4201</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/6/68</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Vally</b>		23d. LOCATION (City or Town) <b>Balto. Co.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Paul E. Chenoweth Jr. 3617 Chestnut Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your PM3. Page 5 may be retained for your files.  
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16968

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16979

1. DECEASED-NAME (Type or Print) <b>THOMAS</b> <b>DEANE</b>		First <b>THOMAS</b>		Middle <b>CALVIN</b>		Last <b>CANTLER</b>		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <b>12 20 1968</b>				2b. HOUR <b>2:45M</b>	
3. SEX <b>Male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>Oct. 29, 1939</b>		6. AGE (In years last birthday) <b>28 29 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>December 20, 1968</b>				2d. HOUR <b>2:45M</b>	
7a. BIRTHPLACE (State or foreign country) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>							
10. CITY OR TOWN OF DEATH <b>Essex</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rt. 40 &amp; White Marsh Blvd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Assembler</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>auto</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Abingdon</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Leight Road, Otter Point</b> <b>866 W. Leight Road</b>					
14. FATHER'S NAME <b>Calvin H. Cantler</b>		15. MOTHER'S MAIDEN NAME <b>Ida Fay Holcomb</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>218-36-1926</b>		17. INFORMANT ADDRESS <b>Folger Brooks, Box 49, Abingdon, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries</b> <b>8129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8161</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>2:04 PM 12 20 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Subject in auto-truck collision</b>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Rt. 40 &amp; White Marsh Essex Balto. Md.</b>									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED <b>12/20/68</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Abingdon Harford Md</b>					
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>				ADDRESS		25a. REGISTAR DATE <b>DEC 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Stella 16980

CERTIFICATE OF DEATH

16980

1. DECEASED-NAME (Type or print) First Middle Last Stella Carmaggio			2a. DATE OF DEATH Month Day Year 12 23 1968		2b. HOUR M
3. SEX F	4. RACE W	5. DATE OF BIRTH 12-16-1875		6. AGE (In years last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Co. Md.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3631 E. Rader R.d.	
14. FATHER'S NAME First Middle Last Joseph Carmaggio		15. MOTHER'S MAIDEN NAME First Middle Last Rose Carmaggio			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-50-3516	17. INFORMANT Address Mrs. Barbusca		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD - chronic congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs - Yrs -
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lee Robbins M.D. DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12/24/68	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/27/68	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore Md.		
24. FUNERAL DIRECTOR Cannino Funeral Home			25a. REC'D BY REGISTRAR DEC 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16970

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16981

1. DECEASED-NAME (Type or Print) <b>Leta Louverta CARR</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <b>December 23 1968 1 PM</b>			2b. HOUR <b>1 PM</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9-7-98</b>	6. AGE (In years last birthday) <b>70</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	IF UNDER 24 HRS MIN. <b>0</b>	2. DATE PRONOUNCED DEAD Month <b>December</b> Day <b>23</b> Year <b>1968</b>
7a. BIRTHPLACE (State or foreign country) <b>W. Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Towson Balto. Co. 21204</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Josephs Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>Jasper T.</b> Middle <b>Bowers</b> Last <b>Bowers</b>			15. MOTHER'S MAIDEN NAME First <b>Lacey N.</b> Middle <b>Maxon</b> Last <b>Maxon</b>			13e. STREET AND NUMBER <b>2605 Wendover Rd.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>216 23 2641</b>		17. INFORMANT ADDRESS <b>21234</b> <b>Mr. Homer H. Carr, 2605 Wendover Rd.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109</b> <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>								
19a. DATE OF OPERATION <b>4201</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <b>12/23/68</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Me. Pk. Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Co. Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>21204</b> <b>Johnson Funeral Home, 8521 Loch Raven Blvd.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



926 3 2 30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

16971										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16982																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
DANIEL										WALTER										CARROLL										Month 12 Day 29 Year 68										12:30 AM																			
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
MALE										WHITE										3/30/90										78 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
MARYLAND										U.S.A.																				BALTIMORE COUNTY																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
FORT HOWARD										VET. ADM. HOSPITAL										CHAUFFEUR Salesman ret.																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND																				BALTIMORE										YES <input type="checkbox"/> NO <input type="checkbox"/>										3438 Leverton Avenue																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										First Middle Last										First Middle Last																													
DANIEL										H. CARROLL										FRANCES										E. KELLY																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
YES										WW I										218 09 22 45										CLIN. RECORDS, VA HOSP. FT HOWARD, MD.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
IMMEDIATE CAUSE (a)										BRONCHOPNEUMONIA										RECENT																																							
4129										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) PULMONARY EMPHYSEMA										OLD																																							
										DUE TO, OR AS A CONSEQUENCE OF																																																	
										(c) ARTERIOSCLEROTIC HEART DISEASED, MARKED																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										4200 BENIGN PROSTATIC HYPERTROPHY																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (X) (this hospital) attended the deceased from 12/21/68, 19, to 12/29/68, 19, that (X) (we) lost the deceased alive on 12/29/68, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										PETER V. JUVAN										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 12/30/68																													
22d. PHYSICIAN'S NAME (Type)										PETER V. JUVAN, M. D.										22e. ADDRESS										VAH FORT HOWARD, MARYLAND																													
23a. BURIAL, CREMATION, or other disposition (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										1/2/69										BALTIMORE NATIONAL Cemetery										BALTIMORE, MARYLAND																													
24. FUNERAL DIRECTOR										ADDRESS										25a. RECEIVED BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
										MORAN FUNERAL HOME										JAN 1 1969										Charles Judge																													
										42nd & Greenmount Ave. Balto. Md.																																																	

VS 4 69

(C)



John J. [illegible]

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16972

16983

1. DECEASED-NAME (Type or print) First Middle Last WILSON HENRY CARTER			2a. DATE OF DEATH Month Day Year 12 13 68			2b. HOUR 5 A M					
3. SEX MALE		4. RACE White		5. DATE OF BIRTH JAN 3, 1891		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) BALTO. MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore CATONSVILLE Md.					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHANGRI-LA NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Building Insp.			12b. KIND OF BUSINESS OR INDUSTRY Telephone Contr.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Smith Ave		
14. FATHER'S NAME First Middle Last William Henry Carter			15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Winks								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. none			17. INFORMANT Miss Betty Rose Carter			Address Pikesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC PARKINSONISM											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 9-15, 1968, to 12-17, 1968, that (I) (we) last saw the deceased alive on 12-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Samuel P. Scalia, M.D.						22c. DATE SIGNED 12-18-68					
22d. PHYSICIAN'S NAME (Type) SAMUEL P. SCALIA, M.D.						22e. ADDRESS 2 SHERWOOD AVE, BALTO., MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Dec. 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Dundee Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Balt., Md.					
24. FUNERAL DIRECTOR Russell Funeral Home		ADDRESS Pikesville, Md.		25a. RECEIVED BY REGISTRAR DATE DEC 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

16883

CHARGE OF DEATH

16883

HENRY

William Henry

William Henry

William Henry

William Henry

179-11-1882 New York

179-11-1882 New York

William Henry

William Henry

179-11-1882 New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16973

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16984

1. DECEASED-NAME (Type or print) <b>LEO</b>			First <b>NMN</b>			Middle <b>CAVE</b>			Last			2a. DATE OF DEATH <b>DEC.</b> Month <b>23</b> Day <b>68</b> Year			2b. HOUR <b>2P</b> M		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>June 17, 1900</b>			6. AGE (In years last birthday) <b>68</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.								
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) <b>DR. BALTO. MED. CENTER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Parkville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>2601 Taylor Ave.</b>					
14. FATHER'S NAME First <b>Eston</b>			Middle <b>Cave</b>			Last			15. MOTHER'S MAIDEN NAME First <b>Sallie</b>			Middle <b>Bowers</b>			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Mrs. Alice M. Cave, 2601 Taylor Ave.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RETROPERITONEAL CA WITH METASTASIS</b> <b>1580</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>158x</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 20</b> , 19 <b>68</b> , to <b>DEC 23</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>DEC. 23</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Mary L</b>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12-23-68</b>								
22d. PHYSICIAN'S NAME (Type) <b>DR. MARY LIM</b>			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>Dec. 27, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memo. Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Parkville, Md.</b>								
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home 4210 Belair Road.</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>								

48074

RECEIVED IN DEPT

10-10-73

RECEIVED

500 1 334

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

16974										16985																								
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH																								
First <b>William</b>					Middle <b>Joseph</b>					Last <b>Chamberlain</b>					Month <b>December</b>					Day <b>18</b>					Year <b>1968</b>					26. HOUR <b>9<sup>30</sup> A M</b>				
3. SEX <b>Male</b>					4. RACE <b>Cauc.</b>					5. DATE OF BIRTH <b>June 28, 1890</b>					6. AGE (In years last birthday) <b>78</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.									
70. BIRTHPLACE (State or foreign country) <b>Maryland</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Baltimore</b>										Md.									
10. CITY OR TOWN OF DEATH <b>Baltimore</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8324 Wyton Road</b>					120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Electrician</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>																			
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>					13c. CITY OR TOWN <b>Baltimore</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER <b>8324 Wyton Road</b>														
14. FATHER'S NAME First <b>Joseph</b>					Middle <b>- - -</b>					Last <b>Chamberlain</b>					15. MOTHER'S MAIDEN NAME First <b>Matilda</b>					Middle <b>- - -</b>					Last <b>Fretwell</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>					16b. SOCIAL SECURITY NO. <b>213 03 3436A</b>					17. INFORMANT Address <b>Mrs. Patricia Zeiler 8324 Wyton Road 21204</b>																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Arteriosclerotic CVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>1 yr.</b>																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201 Diabetes mellitus</b>																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 19, 1968</b> , to <b>Dec 18, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE <b>Joseph F. LiPira M.D.</b>															22c. DATE SIGNED <b>Dec. 20, 1968</b>																			
22d. PHYSICIAN'S NAME (Type) <b>Joseph F. LiPira M.D.</b>															22e. ADDRESS <b>8400 Loch Raven Blvd, Baltimore, Md.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>Dec. 21, 1968</b>					23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>					23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>																			
24. FUNERAL DIRECTOR <b>J. E. Lowell Lemmon</b>															ADDRESS <b>4611 Park Heights Ave.</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 23 1968</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>									

1988

1987

William	Joseph	Chamberlain	December 19	1988
Maria	Carol	June 28, 1980	78	
Maryland	U.S.A.	Baltimore		
Baltimore	8330 Wyton Road	Chamberlain	Electrical	
Maryland	Baltimore	Baltimore	8330 Wyton Road	
Joseph	Chamberlain	Maria	--- --	
--- --	--- --	213 03 3004 Mrs. Patricia Keller 213 03 3004		

Dec. 20, 1988

Joseph F. Keller, M.D. 8400 Loch Haven Blvd, Baltimore, Md.

Dec. 21, 1988 New Cathedral Cemetery Baltimore, Maryland

Lowell Johnson 4411 Park Heights Ave. Dec. 2, 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16975

16986

1. DECEASED-NAME (Type or print) <b>Mary V. Chiariello</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>68</b>			2b. HOUR <b>8:30 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-2-1889</b>		6. AGE (In years lost birthday) <b>79</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>613 Crosby Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>At Home</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>613 Crosby Road 21207</b>		14. FATHER'S NAME First Middle Last <b>Gatano</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Theresa Martino</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Vivian Bunch-613 Crosby Road 21207</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>A.S.C.:V-D</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs</b> <b>years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/4/1968</b> , to <b>12/19/1968</b> , that (I) (we) last saw the deceased alive on <b>11/16/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (view) the body after death.							
22b. SIGNATURE <b>Adnan M. Sonmez M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/19/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Adnan M. Sonmez</b>				22e. ADDRESS <b>1011 Frederick Rd. MD 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Ellsworth Armacost-4600 Liberty Hghts Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>SARAH</b> <sup>First</sup> <b>or SARA</b> <sup>Middle</sup> <b>ROBERTA</b> <sup>Last</sup> <b>CIRINCIONE</b>			2a. DATE OF DEATH <b>12</b> <sup>Month</sup> <b>23</b> <sup>Day</sup> <b>68</b> <sup>Year</sup>			2b. HOUR <b>8:40</b> <sup>A</sup> <b>M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>5/23/15</b>		6. AGE (In years last birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Taneytown Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GR. BALTO. MED. CENTER</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Machine Opr. Crown, Cork &amp;</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Seal</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>3319 Brendan Ave.</b>	
14. FATHER'S NAME <sup>First</sup> <b>Charles W.</b> <sup>Middle</sup> <b>Young</b> <sup>Last</sup>			15. MOTHER'S MAIDEN NAME <sup>First</sup> <b>Sara</b> <sup>Middle</sup> <b>Fringer</b> <sup>Last</sup>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>1579</b>		17. INFORMANT <sup>Address</sup> <b>John Cirincione, husband, above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UPPER GI BLEEDING</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF <b>CARCINOMA OF PANCREAS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>157X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>23</b> Year <b>68</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>6701 N. CHARLES ST.</b>		City or Town <b>BALTIMORE</b>		County <b>BALTIMORE</b> State <b>Md.</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/23/68</b> to <b>12/23/68</b> , that (I) (we) lost saw the deceased alive on <b>12/23/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>BEN F. HUGHES, M.D.</b>				DEGREE <b>MD.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/23/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>BEN F. HUGHES MD.</b>				22e. ADDRESS <b>6701 N. CHARLES ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Taneytown Luth. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Taneytown, Md.</b>			
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>				25a. REC'D BY REGISTRAR <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1874

RECORD OF DEATH

1874

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
AGE AT DEATH  
SEX  
COLOR  
RELATIONSHIP TO DECEASED  
OCCUPATION  
CAUSE OF DEATH  
PLACE OF BURIAL

25372

White

Male

DEATH

DEATH

W. L. L. L.

DEATH

W. L. L. L.

DEATH

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W. L. L. L.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 408  
1-3-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16977

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16988

1. DECEASED-NAME (Type or Print) First Middle Last CATHERINE L CLARK			2a. DATE KNOWN OF DEATH Month Day Year 12/30 1968			2b. HOUR OF DEATH 7:30 P.M.			
3. SEX female	4. RACE white	5. DATE OF BIRTH April 17, 1919	6. AGE (In years lost birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year December 30, 1968			2d. HOUR 7:30 P.M.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 209 Ridgely Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 209 Ridgely Road	
14. FATHER'S NAME First Middle Last Otto Lissau			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Whyte						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-07-2747		17. INFORMANT James B. Clark			ADDRESS Same as # 13 E		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty Liver/ Barbiturate overdose</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 9500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. DATE OF OPERATION 9702									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 2:00 P.M. 12/30 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Subject ingested an overdose of drugs				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Lutherville		City or Town Baltimore		State Md.	
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Werner U. Spitz</u>			M.D. Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/31/68	
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-4-69		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION (City or Town) (County) (State) Cockeysville Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.				ADDRESS Towson, Md. 21204		25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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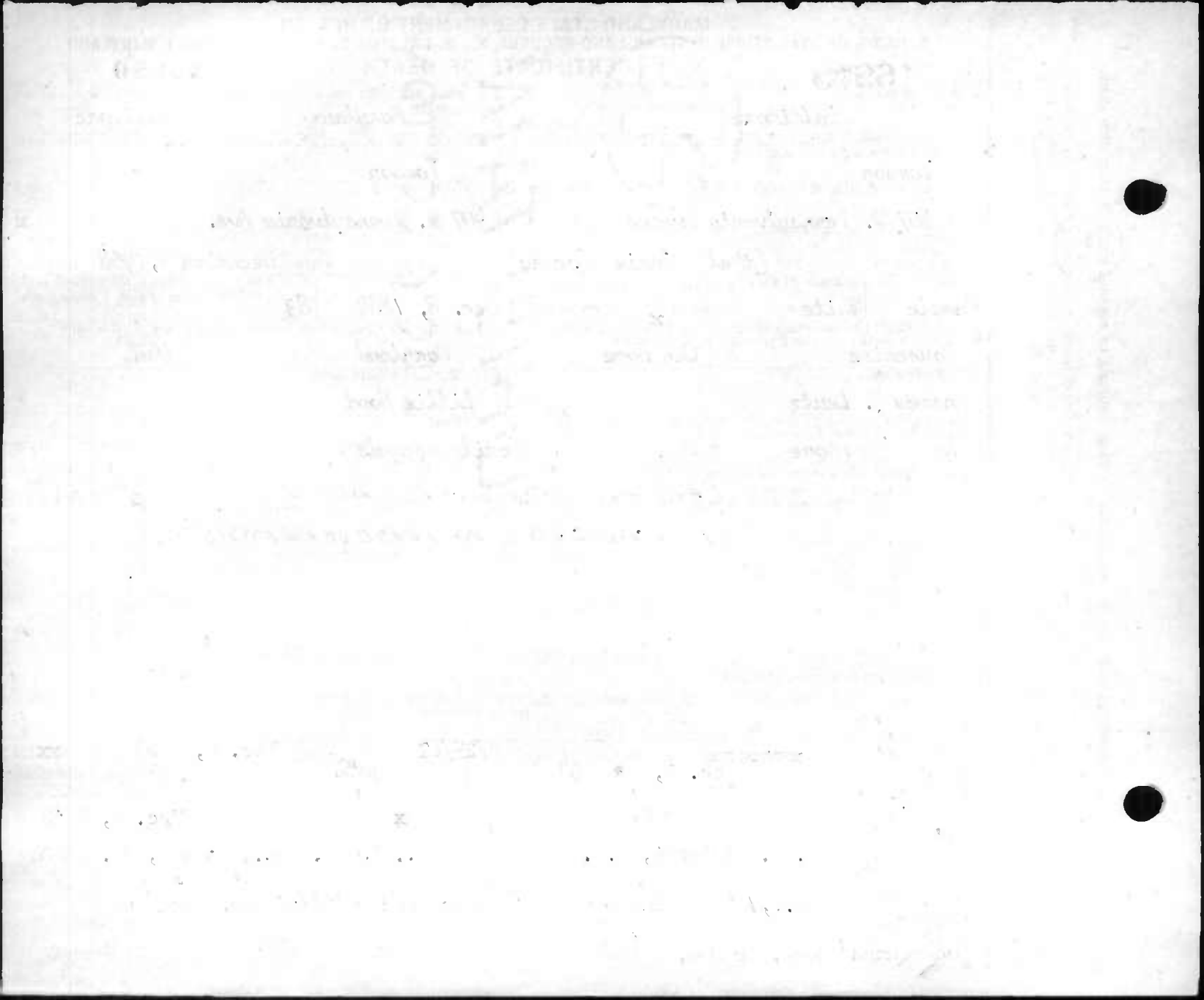
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i> c. LENGTH OF STAY IN 1b <i>Towson</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>407 W. Pennsylvania Avenue</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> d. STREET ADDRESS <i>407 W. Pennsylvania Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ethel Marie Cockey</i>	4. DATE OF DEATH Month <i>December</i> Day <i>4</i> Year <i>1968</i>	5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Dec. 8, 1884</i> 9. AGE (In years last birthday) <i>83</i> yrs. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Andrew J. Leutz</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Hood</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i> 17. INFORMANT <i>Family records</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRO VASCULAR ACCIDENT</i> <i>4369</i> DUE TO (b) <i>GENERALIZED ARTERIO SCLEROSIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>331X</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <i>this hospital</i> attended the deceased from <i>9/25/62</i> , 19 <i>62</i> , to <i>Dec. 4</i> , 19 <i>68</i> , that (I) <i>we</i> last saw the deceased alive on <i>Dec. 3</i> , 19 <i>68</i> , and that death occurred at <i>10:10</i> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>T. C. Siwinski</i>		22b. DATE SIGNED <i>Dec. 6, 1968</i>	
22c. PHYSICIAN'S NAME (Type) <i>T. C. Siwinski, M.D.</i>		22d. ADDRESS <i>206 W. Penna. Ave., Towson, Md. 21204</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 7, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR <i>DEC 9 1968</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Bertha Estelle Corant</i>			2a. DATE OF DEATH Month <i>12</i> Day <i>3</i> Year <i>68</i>		2b. HOUR <i>11:15</i> AM
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>July 27, 1878</i>		6. AGE (In years last birthday) <i>90</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Belts Co., Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md.		
10. CITY OR TOWN OF DEATH <i>Cockeysville, Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Marian Home, Md.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Shoe</i>	12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Baltimore</i>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER <i>4304 Grandview Ave.</i>		
14. FATHER'S NAME First Middle Last <i>Thomas - Sparger</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary - Lewis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>215-05-3517</i>		17. INFORMANT Address <i>Renda M. Marion Home, Cockeysville</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis Vas. Dis.</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>4500</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1</i> , 19 <i>68</i> , to <i>Dec. 3</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Dec. 3</i> , 19 <i>68</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
22b. SIGNATURE <i>Carl F. Benson md</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>Dec. 3, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Carl F. Benson md</i>		22e. ADDRESS <i>5111 York Rd. Balt. Md 21212</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12-5-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR <i>Wm Cook-Brooks Towson</i>		ADDRESS <i>1050 York Rd Towson Md 21204</i>		25a. REC'D BY REGISTRAR <i>DEC 4 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

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Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Anita Carlyle Cooper			2a. DATE OF DEATH Month Day Year 12 3 1968			2b. HOUR P. 1:30 M	
3. SEX female		4. RACE white		5. DATE OF BIRTH 12/23/1893		6. AGE (In years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) Bermuda		7b. CITIZEN OF WHAT COUNTRY? Bermuda		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson, Maryland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Towson Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Bermuda		13b. COUNTY Southampton		13c. CITY OR TOWN Petersfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last J.D. Carlisle		15. MOTHER'S MAIDEN NAME First Middle Last ????? Hollis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. -----	
17. INFORMANT Dulaney Towson Nursing Home, 111 West Road		Address 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 437.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro-vascular arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-8-1966</u> to <u>12-3-1968</u> , that (I) (we) last saw the deceased alive on <u>12-2-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Keith A. Manley		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-3-68			
22d. PHYSICIAN'S NAME (Type) KEITH A. MANLEY		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-7-1968		23c. NAME OF CEMETERY OR CREMATORY Bailey's Bay Cem.		23d. LOCATION (City or Town) (County) (State) Hamilton Parish, Bermuda	
24. FUNERAL DIRECTOR Perinchief Fun. Home, West Hamilton, Bermuda		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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Carbo. variabilis carbo. variabilis

10.5 68  
8.8 68  
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15.2 68  
KEITH A. WILLEY  
10.5 68  
8.8 68  
10.3 68  
15.2 68

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Ernest S. Cooper						Month Day Year		Hour		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	White	Sept. 24, 1901	67 YRS.	MONTHS	DAYS	Month Day Year		Hour		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Middle River 21220			55 "B" Oak Grove Dr.			Driver		Trucking		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Baltimore		Middle River		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		55 "B" Oak Grove Dr.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Last				
John Cooper			Mary Gray							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No			212 09 3829		Joseph Holter		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>A-S-C-U-Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
4221										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED				
<u>M.B. Davis</u>						12/9/68				
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER							
M.B. Davis, MD										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			12/11/68		Baltimore Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James E. Bruzdinski					1407 Eastern Ave. 21221		DEC 12 1968		Charles Judge	

10003

Walter J. Cooper

White Capt. 1001 02

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Walter J. Cooper

White Capt. 1001 02

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White Capt. 1001 02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> 169983  1 X </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH  DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div> <div> 169994 </div> </div>											
1. DECEASED-NAME (Type or print) <b>ROSE</b>			First Middle Last			2a. DATE OF DEATH <b>DECEMBER</b> Month <b>25</b> , Day <b>1968</b>			2b. HOUR <b>1:30A</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>January 20, 1892</b>			6. AGE (In years lost birthday) <b>76</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE,</b> Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>1210 WOODBOURNE AVE. #21212</b>			14. FATHER'S NAME First Middle Last <b>Samuel Leonard</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Bridget</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Rose Adelson</b> Address <b>same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intestinal infarction</b> <b>4442</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>5702</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>December 22 19 68</b> , to <b>December 25 19 68</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>December 25, 19 68</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I)</del> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									22c. DATE SIGNED <b>12-25-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Ines Gilliani, M.D.</b>									22e. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>		
23a. BURIAL, CREMATION, REBURY (Type) <b>Burial</b>			23b. DATE <b>12/28/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Le onard J. Ruck Inc. Balto. Md.</b>						25a. REC'D BY REGISTRAR <b>DEC 26 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



Be to .

London Park

25/28/28

Initial

23/28/28

Be to .

London Park

Initial

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 10 Film 108  
1/8/69 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16995

1. DECEASED-NAME (Type or Print) First Middle Last <b>KIMBERLY ANN CORBETT</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>12-26 1968</b>			2b. HOUR M <b>11:00</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Eight 6 weeks</b>		6. AGE (In years last birthday) YRS. MONTHS DAYS <b>2 2</b>		7c. DATE PRONOUNCED DEAD Month Day Year <b>December 26, 1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>	
10. CITY OR TOWN OF DEATH <b>Baynesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If none, give street address) <b>Bend Drive 8700 Apt. D Loch Raven Blvd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Child</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Bend Drive</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Thomas Reid Corbett</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Mae Weatherman</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT ADDRESS <b>Thomas R. Corbett, 8700 Loch Bend Drive</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral otitis media (SDII)</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19a. DATE OF OPERATION <b>381.9</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED <b>December 26, 1968</b>			22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12-28-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Md. Pk Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Co. Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>William E. Johnson 8521 Loch Raven Blvd. 21204</b>			25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

10

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23c per telep  
conv. with

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16996

1. DECEASED-NAME (Type or Print) First Middle Last DARWIN W. COREY			2a. DATE KNOWN OF DEATH Month Day Year 12-14-1968			2b. HOUR 1:20 A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1/15/1921	6. AGE (in years last birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year December 14 1968		2d. HOUR 1:20 A.M.
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CORRECTIONAL GUARD		12b. KIND OF BUSINESS OR INDUSTRY PENAL	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last OLIVER COREY		15. MOTHER'S MAIDEN NAME First Middle Last ANECIA TRICKETT		13e. STREET AND NUMBER 8118 N. Boundary Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) NW DL 234-26-5230		17. INFORMANT ADDRESS MARY J. COREY - AS IN # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lacerations of mesentery with hemoperitoneum</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>8120</u> <u>8161</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>See 21f--Accident enroute to work.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR:MIN 11:00 P.M. 12-13 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of pickup Truck which struck parked			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street		21f. LOCATION Street or R.F.D. No. City or Town County State Lochraven & Northern Prkwy. Baltimore Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED December 14, 1968	
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/17/1968		23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		23d. LOCATION (City or Town) (County) (State) DORSEY, Md.	
24. FUNERAL DIRECTOR Walter Burke Bradley, Dundalk, Md.		25a. REC'D BY REGISTRAR DATE DEC 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

15558

10-15-1963

10-15-1963

10-15-1963

10-15-1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

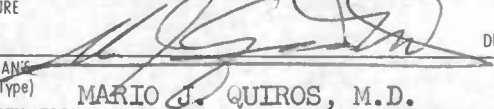
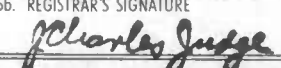
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16986

CERTIFICATE OF DEATH

16997

1. DECEASED-NAME (Type or print)		First PAUL		Middle CHARLES		Last CORNELIUS SR.		2a. DATE OF DEATH Month Day Year DECEMBER 7, 1968			2b. HOUR 1:10 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JULY 12, 1920			6. AGE (In years lost birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE						
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (Give street address) HOSPITAL VETERANS ADMINISTRATION		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3313 RAVENWOOD AVENUE				
14. FATHER'S NAME First Middle Last HIRAM CORNELIUS		15. MOTHER'S MAIDEN NAME First Middle Last FLORENCE STAHL										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16b. SOCIAL SECURITY NO. 170 12 6027		17. INFORMANT Address CLINICAL RECORDS, VAH FT HOWARD, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA, MASSIVE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MULTIPLE PULMONARY EMBOLI DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCTION WITH MURAL THROMBOSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS WEEKS YEARS												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from 11/6/68, 19__, to 12/7/68 19__, that (X) (we) last saw the deceased alive on 12/7/68 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE 		DEGREE MARIO J. QUIROS, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12 8 68						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/12/68		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND						
24. FUNERAL DIRECTOR ADDRESS MORAN FUNERAL HOME, 3000 E BALTO ST, BALTO, MD		25a. REC'D BY REGISTRAR DATE DEC 11 1968		25b. REGISTRAR'S SIGNATURE 								

10001

10001

V

DEC 1 1968

DEC 23 1968

noted  
12/23/68 in  
(already noted  
before by  
J. Jones)

To Whom It May Concern

I Mrs Betty C. Cornelius wife  
of Paul Charles Cornelius Sr. who  
died on Dec. 7-1968 at Fort Howard  
Hospital in Baltimore County do  
not wish to have any certificate  
of death given to anyone under  
any circumstances what so ever.

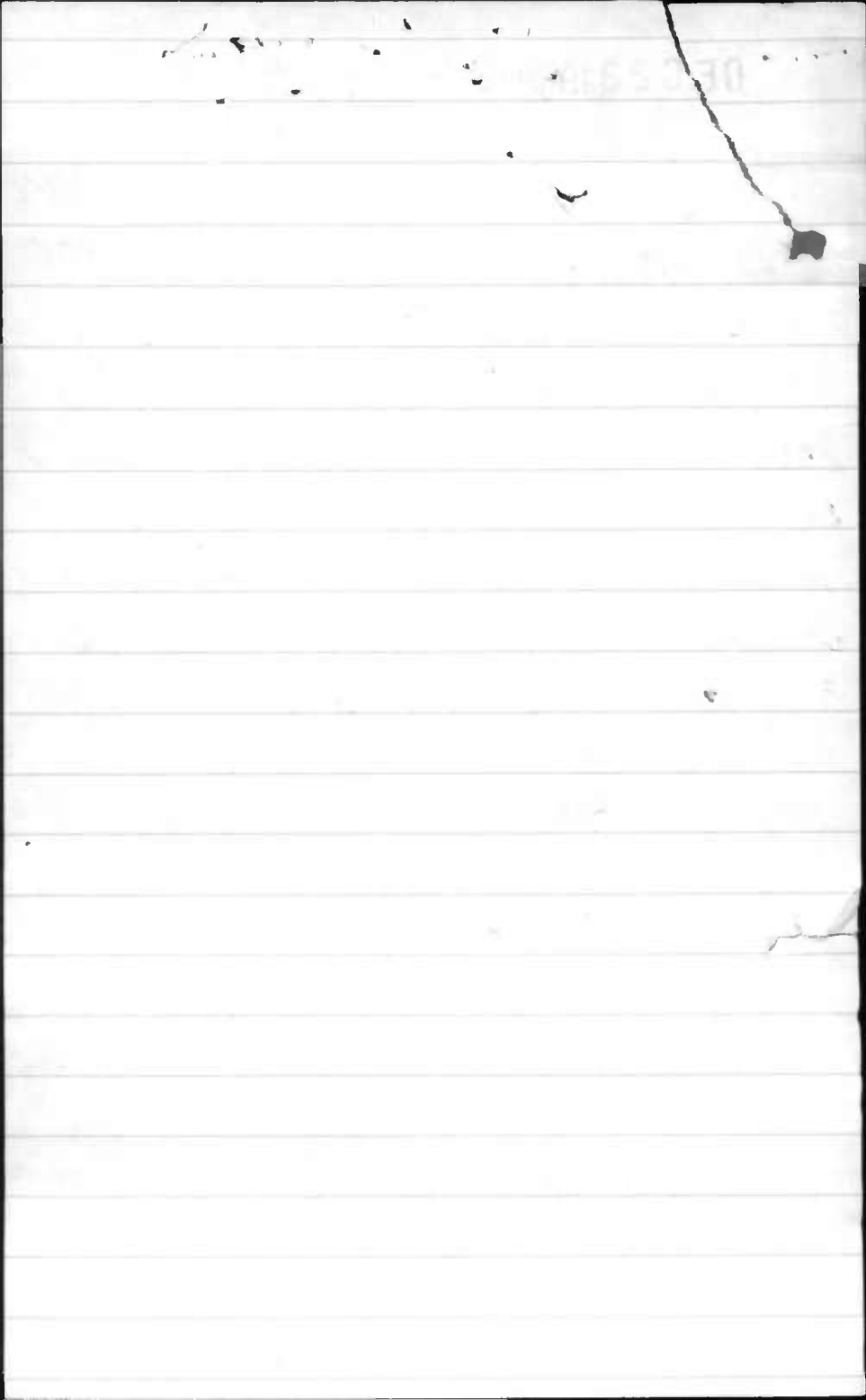
Thank You Very Much

Mrs Betty C. Cornelius

1629 Gail Road Apt 2

Baltimore 21221

Maryland.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)		First Fred.		Middle S.		Last Corson		2a. DATE KNOWN OF ESTI- DEATH MATED		Month Day Year 12 25 1968	
3. SEX Male		4. RACE W.		5. DATE OF BIRTH 3-15-1907		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.		2c. DATE PRONOUNCED DEAD Month Day Year 12 25 1968		2d. HOUR 8:45 AM	
10. CITY OR TOWN OF DEATH Towson XXX 21212				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6900 Lackland Cir				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chief Eng.		12b. KIND OF BUSINESS OR INDUSTRY Merch. Marine	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Towson 21212		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6900 Lackland Cir.	
14. FATHER'S NAME First Middle Last Fred S. Corson, Sr.				15. MOTHER'S MAIDEN NAME First Middle Last Maude Bryant							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 217-16-4328		17. INFORMANT Dorothy H. Corson					
						ADDRESS same as 13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) 5+yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 12-25-1968			
ADDRESS (Street, city, town, or county) 7501 York Rd.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-28-1968		23c. NAME OF CEMETERY OR CREMATORY Wood lawn		23d. LOCATION (City or Town) Balto., Md.		(County)		(State)	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc.				ADDRESS 1050 X York Rd. Towson, Md. 21204		25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16988

CERTIFICATE OF DEATH

16999

1. DECEASED-NAME (Type or print) <b>Eugenia E. Cost</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>6:15 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7/25/96</b>		6. AGE (In years lost birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>24 N. Belgrove Rd</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>24 N. Belgrove Road 21228</b>	
14. FATHER'S NAME First Middle Last <b>George Snyder</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Eleanore Rabbitt</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>Mr. Horace F. Cost, Sr., 24 N. Belgrove Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary atherosclerosis &amp; chronic heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>several years</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201 none</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>29 Jan, 1966</b> , to <b>9 Dec, 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>10 Oct 1968</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.										
22b. SIGNATURE <b>W. K. Gallager, Jr. M.D.</b> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10 Dec 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. Wilmer K. Gallager, Jr</b>						22e. ADDRESS <b>6630 Baltimore National Pike</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Witzke, 4101 Edmondson Avenue, 21229</b>						25a. REC'D BY REGISTRAR <b>DEC 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>16989</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17000</div>									
1. DECEASED-NAME (Type or print) First Middle Last <b>BERT RIDDELL CRAMER</b>					2a. DATE OF DEATH 12 Month 27 Day 68 Year			2b. HOUR 8:45 PM	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH 10/17/19			6. AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE Co.</b> Md.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CEN.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Ass't. General Fore-Beth.Steel</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2916 Alvarado Sq.</b>		
14. FATHER'S NAME First Middle Last <b>Bert Riddell Cramer</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Bromwell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>			16b. SOCIAL SECURITY NO. <b>217-14-5474</b>		17. INFORMANT Address <b>Viola Cramer-2916 Alvarado Sq.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bowel Malignancy; COLON CANCER (Chronic)</b> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1538									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (A) (this hospital) attended the deceased from <b>11-28</b> , 19 <b>68</b> , to <b>12-27</b> , 19 <b>68</b> , that (B) (we) lost saw the deceased alive on <b>December 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. Morteza</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-27-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>DR. MORTEZA MOUSSAVI, M.D.</b>					22e. ADDRESS <b>6701 N. Charles St. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16990										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17001									
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR									
SHERWOOD										CRUSE										Month 12-24- Day 68 Year 7:10 PM									
3. SEX MALE										4. RACE WHITE										5. DATE OF BIRTH 10-16-12									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
10. CITY OR TOWN OF DEATH TOWSON										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Parkville									
14. FATHER'S NAME First Middle Last Maynard Cruse										15. MOTHER'S MAIDEN NAME First Middle Last Katherine Schoen										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or no (own) (If yes give war or dates of service) none									
17. INFORMANT Address										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
22a. I certify that (X) (this hospital) attended the deceased from 12-21-1968, to 12-24-1968, that (X) (we) last saw the deceased alive on 12-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										22b. SIGNATURE L. Gaudiel, M.D.										22c. DATE SIGNED 12-24-68									
23a. BURIAL, CREMATION, or other disposition Burial										23b. DATE 12/28/68										23c. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cem.									
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.										25a. REC'D BY REGISTRAR DEC 26 1968										25b. REGISTRAR'S SIGNATURE J. Charles Judge									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16991												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												17002			
Item 7 Film G408 1/2/69 kk												CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR															
Lucinda Massey Cunabaugh								12/ 16/ 68				Day Year				11.45 AM											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years lost birthday)				IF UNDER 1 YEAR				IF UNDER 24 HRS.							
F				W				2/28/82				88 YRS.				MONTHS DAYS HOURS MIN.											
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				Md.											
England				US								Baltimore															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore				Augsburg Luth Home				Receptionist																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER											
Md				Howard				Ellicott City				NO				Route 2											
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last																							
James MASSEY				Cambell																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address															
				212-03-0699				Records				A.L.H. 6811 Campfield Rd															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I. DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) <i>Adeno carcinoma of uterus</i>												3 yrs.															
1829 DUE TO, OR AS A CONSEQUENCE OF																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																											
(b) <i>Diabetes Mellitus</i>												10 yrs.															
DUE TO, OR AS A CONSEQUENCE OF																											
(c) <i>Arterio Sclerotic Heart Disease</i>												5 yrs															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																											
174X <i>Generalized arterio Sclerosis</i>																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1961</i> , to <i>dec. 1968</i> , that (I) <del>(was)</del> lost																											
saw the deceased alive on <i>12/15</i> 1968, and that in (my) <del>(was)</del> opinion death occurred on the date and hour and from the																											
causes stated above, (I) <del>(was)</del> (did) (did not) view the body after death.																											
22b. SIGNATURE <i>Earl L. Chambers M.D.</i> DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED <i>12/13/68</i>															
22d. PHYSICIAN'S NAME (Type) <i>Earl Chambers</i>												22e. ADDRESS <i>100-W. Cold Spring Bay Balto. Md.</i>															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)															
Burial				12/13/68				Loudon Park				Baltimore															
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Paul A. Heemann				6067 Harford R.,				DATE DEC 16 1968				<i>J. Charles Judge</i>															

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VR A151-1  
30M REV. 1-64

16992		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		17003	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
LUGI				CURRO	DEC Month 1 Day 1968 Year		10 <sup>45</sup> AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE	WHITE		1/7/89		79 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
SICILY		US				Baltimore County, Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Mount Wilson		Mt. Wilson State Hosp.		SHOE REPAIR MAN			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD.		PRINCE GEORGES		CHILLUM		5607 BURGESS DRIVE	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
PAUL			L.	CURRO	ANTONINA GRASSO		CURRO
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No		578-48-3697		Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident with Rt. Hemiplegia							8 mo.
4369 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS, GENERALIZED							10 YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
331X MILIARY TUBERCULOSIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from JUNE, 1968, to DEC, 1968, that (I) (we) last saw the deceased alive on DEC 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED					
W Newcomer		DEC 3 1968					
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS		22f. DATE SIGNED			
		Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
ENTOMBMENT		4 DECEMBER 1968		FORT LINCOLN MAUSOLEUM		BLADENSBURG MARYLAND	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
RINALDI FUNERAL HOME, WASH., D.C.		7400 GA. AVE		DATE DEC 3 1968		Charles Judge	

Eastern County

John Wilson

Mount Wilson, Maryland

William H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body after death.

16998										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17004									
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR									
WILLIAM H. CURTIS JR.										December 12, 1968										3:45 AM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. HOURS			MIN											
Male			White			April 20, 1915			53																				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			USA						Baltimore																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Towson			St. Joseph Hospital			Md. State Fair																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER																				
Maryland			Baltimore			Cockeysville			YES			829 Warren Rd.			21030														
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																										
William Harrison Curtis Sr.			Rosa Virginia Curtis																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																				
No			217-16-4259			Mrs. Roseanna Curtis			Same as # 13 E																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure with Atrial Fibrillation																													
5719 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Cirrhosis of the Liver																			
										DUE TO, OR AS A CONSEQUENCE OF																			
										(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
5810																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from November 29, 1968, to Dec. 12, 1968, that (I) (we) last saw the deceased alive on December 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Camilo L. Tomboc										22c. DATE SIGNED 12-12-68																			
22d. PHYSICIAN'S NAME (Type) Camilo L. Tomboc, M.D.										22e. ADDRESS 7620 York Rd., Towson Md. 21204																			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
Burial			12-14-68			Poplar Grove Cemetery			Cockeysville			Maryland																	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.										25a. REC'D BY REGISTRAR DEC 13 1968																			
1050 York Road Towson, Md. 21204										25b. REGISTRAR'S SIGNATURE J. Charles Judge																			

1005

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "and", "the", "of" are visible.]*

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <b>HELEN</b>			First <b>M.</b>		Middle <b>DAILEY</b>		Last		2a. DATE OF DEATH December <sup>Month</sup> 20 <sup>Day</sup> 1968 <sup>Year</sup>		2b. HOUR 9:55 <sup>PM</sup>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>April 22, 1903</b>			6. AGE (In years lost birthday) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>			Md.	
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1408 Maywood Ave.</b>			
14. FATHER'S NAME First <b>Clifton</b>			Middle <b>Sykes</b>			Last			15. MOTHER'S MAIDEN NAME First <b>Sarah</b>			Middle <b>Lindsey</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>215-01-7922A</b>			17. INFORMANT <b>Fred N. Dailey</b> Address <b>1408 Maywood Ave. 21204</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pulmonary thrombo-embolism</b> <b>4510</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Thrombophlebitis, left leg</b> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>463X</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> , 19 <b>68</b> , to <b>12-20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Ines Cilliani</b>									DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Dec. 20, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M. D.</b>						22e. ADDRESS <b>7620 York Road, Towson 4, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			23b. DATE <b>12/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd. #21212</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

1002

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)  
30M REV. 1/68

16995										MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17006																			
1. DECEASED-NAME (Type or print) First Middle Last John DANE										2a. OATE OF OEATH Month Day Year Dec 21 1968										2b. HOUR 10:15 PM																													
3. SEX M										4. RACE Cauc										5. OATE OF BIRTH 3/22/1886										6. AGE (In years last birthday) 82 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Wisconsin										7b. CITIZEN OF WHAT COUNTRY? U.S.A										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																			
10. CITY OR TOWN OF DEATH Catozville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sharyra-ba Nursing Home										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman										12b. KIND OF BUSINESS OR INDUSTRY Power tools																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md										13b. COUNTY Balt										13c. CITY OR TOWN Catozville										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 6007 Johnnycake Rd.									
14. FATHER'S NAME First Middle Last Frederick T DANE										15. MOTHER'S MAIDEN NAME First Middle Last Ida Reynolds																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 215-10-1013										17. INFORMANT Ruth Harris										Address 6007 Johnnycake Rd Balt.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: not related IMMEDIATE CAUSE (a) Bronchopneumonia To Influenza DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) 485X stating the underlying cause last. 497X DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Parkinsons Disease, Chronic Urinary tract infect, Eosinophilia, Dehydration, Ascuid																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (U) (this hospital) attended the deceased from 12 NOV 1968, to 21 Dec 1968, that (U) (we) last saw the deceased alive on 21 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (U) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Richard R. Stephenson MD										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 21 Dec 1968																													
22d. PHYSICIAN'S NAME (Type) Richard Rider Stephenson										22e. ADDRESS 1302 Crofton Road Balt. Md 21212																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 12/24/68										23c. NAME OF CEMETERY OR CREMATORY Woodlawn										23d. LOCATION (City or Town) (County) (State) Woodlawn, Balt Co Md																			
24. FUNERAL DIRECTOR Wm. Cook-Brecks West Inc Balt. Md.										25a. REC'D BY REGISTRAR DATE DEC 30 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

14008

RECEIVED

14008

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
Matilda				Daniels	12/10/68		11:45		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
F	W		1/8/95		73				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Poland		U.S.A.				Baltimore, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonville		Summit M.H.		Seamstress		Shirt Mfg.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		BALTO		BALTO.				4215 Wilschire Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		Address					
First Middle Last		First Middle Last							
Martin		Wolski		Maryanna Lublenska					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT					
		216-14-7575		Mrs. Cordelia Woody, 5200 Talbot Pl. (27)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the head of the									
1570 DUE TO, OR AS A CONSEQUENCE OF pancreas									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) Intermittent									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
157X by Dr. MECH.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
11/14/68		Explor. Laparotomy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING? <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11/22, 1968, to 12/10, 1968, that (I) (we) last saw the deceased alive on 12/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
E. KASARI, M.D.						12/11/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
E. KASARI, M.D.		1801 Frederick Road Baltimore, Md.		21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/14/68		St. Stanislaus		Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
M.F. SADOWSKI & SONS, 1808 EASTERN AVE						DATE DEC 13 1968		Charles Judge	

15003

15003

15003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16997

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17008

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR P	
Baby		DANNENFELSER		DECEMBER 27, 1968		11:30 P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male	WHITE	DECEMBER 27, 1968		YRS.	2		59
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		Md.		
MARYLAND	USA	BALTIMORE					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON 4		ST. JOSEPH HOSPITAL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
MARYLAND		BALTO.	BALTIMORE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	9416 Dana Vista Road		
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
CARL DANNENFELSER		BARBARA KALBSKEPP					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address				
			Carl E Dannenfels 9416 Dana Vista				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY							
777x DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
776x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from DEC. 27, 1968, to DEC. 27, 1968, that (X) (we) last saw the deceased alive on Dec. 27, 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED					
Ayestarain		Dec. 27, 1968					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
E. Ayestarain, M.D.		7620 York Road, Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		12/30/68		Parkwood Cem.		Parkville Balto. Co. Md	
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Lassell Funeral Home		7401 Belair Rd.		JAN 3 1969		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16998

CERTIFICATE OF DEATH

17009

1. DECEASED-NAME (Type or print)		First <b>Richard</b>		Middle <b>Daros</b>		Last <b>Daros</b>		2a. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>1968</b>			2b. HOUR <b>11:55</b> AM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 13, 1913</b>			6. AGE (In years last birthday) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS <b>55</b> DAYS <b>55</b>		IF UNDER 24 HRS. HOURS <b>55</b> MIN <b>55</b>	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore,</b> Md.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Bricklayer</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>301 Joplin St.</b>				
14. FATHER'S NAME First <b>Anthony</b> Middle <b>DaRes</b>		15. MOTHER'S MAIDEN NAME First <b>Rose</b> Middle <b>Casagrande</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>081-09-8973</b>		17. INFORMANT Address <b>Mrs. Rita C. DaRes Same</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYELOGENOUS LEUKEMIA</b> <b>2051</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2041</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____								
22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>12/12/</b> , 19 <b>68</b> , to <b>12/26/</b> , 19 <b>68</b> , that <b>10</b> (we) last saw the deceased alive on <b>12/26/</b> , 19 <b>68</b> , and that in <b>(our)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Samuel C. H. Lee, M.D.</b>		22c. DATE SIGNED <b>12/26/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Samuel C. H. Lee, M.D.</b>								
22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR <b>Leonard J. Puckler</b>		ADDRESS <b>5305 Harford Rd.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>						

17002

UNITED STATES OF AMERICA

17002

FROM: [illegible]

TO: [illegible]

DATE:

10/10/58

100-10-10

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10/10/58

100-10-10

10/10/58

100

100-10-10

Davis

16999

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Frank</i>		First	Middle	Last	2a. DATE OF DEATH Month <i>Dec</i> Day <i>16</i> Year <i>68</i>		2b. HOUR 12 <sup>45</sup> <sub>A</sub> M		
3. SEX <i>male</i>	4. RACE <i>White</i>		5. DATE OF BIRTH <i>August 14, 1909</i> <i>Dec 16, 1908</i>		6. AGE (In years lost birthday) <i>34</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Munnsville N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.			
10. CITY OR TOWN OF DEATH <i>Cattonsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Bacteriologist Ret.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dairy Eng.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Pikesville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4202 Lowell Dr. 21208</i>	
14. FATHER'S NAME First <i>Thomas</i> Middle <i>Davis</i> Last				15. MOTHER'S MAIDEN NAME First <i>Melora</i> Middle <i>Unknown</i> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>216-03-9426</i>		17. INFORMANT Address <i>Mrs. Sarah L. Davis 4202 Lowell Dr. 21208</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>471X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Influenza</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Cardiovascular</i> <i>disease; Complete Heart Block</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>480X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/15</i> , 19 <i>67</i> , to <i>12/16</i> , 19 <i>68</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>12/15</i> , 19 <i>68</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> (did not) view the body after death.									
22b. SIGNATURE <i>Edmund K. ...</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/16/68</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/18/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville Balto. Co. Md.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Loring Byers 8728 Liberty Rd. Randallstown, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

17000										17011									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Anna					First Middle Lost M. Dembowski					2a. DATE OF DEATH December 12 <sup>Day</sup> 1968 <sup>Year</sup>					2b. HOUR M				
3. SEX F			4. RACE W			5. DATE OF BIRTH 10-10-1894				6. AGE (In years lost birth day) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore Md.									
10. CITY OR TOWN OF DEATH Arbutus			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8 Colony Hill Court 27				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland					13b. CITY OR TOWN Baltimore			13c. CITY OR TOWN Arbutus			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 8 Colony Hill Court 21227					
14. FATHER'S NAME First Middle Lost Lawrence Handzlik					15. MOTHER'S MAIDEN NAME First Middle Lost (Unknown)														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No					16b. SOCIAL SECURITY NO. --			17. INFORMANT Address Robert Hegan, 8 Colony Hill Rd. Arbutus 27											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, acute</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u> <u>Diabetes mellitus</u>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, etc.) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> , 19 <u>68</u> , to <u>12/12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Herbert J. Levickas, M.D.</u>					22c. DATE SIGNED <u>12/12/68</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (Type) Herbert J. Levickas					22e. ADDRESS 5404 East Drive, Balto. 21227														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-16-68			23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) (County) (State) Sharpsburg, Pennsylvania										
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. Balto					25a. REC'D BY REGISTRAR DATE DEC 16 1968					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>17001</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>17012</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>																	
1. DECEASED-NAME (Type or print)			First <b>WILLIAM</b>			Middle <b>JOSEPH</b>			Last <b>DEMPSEY</b>			20. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>11:15 PM</b>		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>12/7/91</b>			6. AGE (In years lost birthday) <b>76</b> YRS.			IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>			Md.					
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL, FT HOWARD, MD.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CLERK</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OIL CO</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER <b>15 E. Center Street</b>					
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>B.</b> Last <b>DEMPSEY</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>L.</b> Last <b>KING</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give year or dates of service) <b>WW I</b>			16b. SOCIAL SECURITY NO. <b>212 12 55 16</b>			17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PHEOCHROMOCYTOMA, BILATERAL, ADRENALS WITH HEMORRHAGE</b> <b>255.2</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>224X</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE, OLD. PULMONARY EMPHYSEMA, BILATERAL, OLD</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____											
22a. I certify that (1) (this hospital) attended the deceased from <b>10/29/68</b> , 19____, to <b>12/5/68</b> , 19____, that (1) (we) last saw the deceased alive on <b>12/5/68</b> , 19____, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Erhard J. Bunyor M.D.</b>															22c. DATE SIGNED <b>12/6/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>ERHARD J. BUNYOR, M. D.</b>			22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12-9-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>								
24. FUNERAL DIRECTOR			ADDRESS <b>WM. COOK BROOKS INC.</b>			25a. RECEIVED BY REGISTRAR <b>DEC 9 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First JACK			Middle BRYANT			Last DENNING			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 12-25 1968			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 14, 1931		6. AGE (In years last birthday) 37 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year December 25, 1968			2d. HOUR 8:10 P.M.		
7a. BIRTHPLACE (State or foreign country) N.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.								
10. CITY OR TOWN OF DEATH White Marsh				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rte. 40 east of Ebenezer Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Steel Worker				12b. KIND OF BUSINESS OR INDUSTRY Bethlehem					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN Joppatown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 826 Bradley Rd.							
14. FATHER'S NAME First Middle Last Joel -- Denning			15. MOTHER'S MAIDEN NAME First Middle Last Vivian -- Keene			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16b. SOCIAL SECURITY NO. (If yes give war or dates of service) Korean 257-44-3743		17. INFORMANT ADDRESS John F. Denning, Rt. 16, Box 513, Balto. Md. 21220			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2164																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 7:00 A.M. 12-25 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver in auto-auto collision									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) highway				21f. LOCATION Street or R.F.D. No. City or Town County State Rte. #40 1/2 ml. E. of White Marsh Balt. Md. Ebenezer Rd.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED December 26, 1968									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Dec. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery				23d. LOCATION (City or Town) (County) (State) Joppa Harford Md.							
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. REGISTRY REGISTRAR DATE DEC 30 1968				25b. REGISTRAR'S SIGNATURE Charles Judge									

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• **Journal of Management Education** 34(10):1039-1050, 2010. © 2010 Sage Publications. 10.1177/0022032110381011

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17093

CERTIFICATE OF DEATH

17014

1. DECEASED-NAME (Type or print)		First Carl	Middle William	Last DeTar	2a. DATE OF DEATH Month Day Year December 22 68		2b. HOUR P 9.30M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11-5-17			6. AGE (In years last birthday) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Kan.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dispatcher		12b. KIND OF BUSINESS OR INDUSTRY H.T. Campbell		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9019 Carlisle Ave., 21236			
14. FATHER'S NAME First Middle Last William H. DeTar			15. MOTHER'S MAIDEN NAME First Middle Last Mattie Elliott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO. 513-05-2340		17. INFORMANT Address Doris Mary DeTar-9019 Carlisle Ave.-21236				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 571.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Laennec Cirrhosis DUE TO, OR AS A CONSEQUENCE OF (c) 581.1 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12-20-1968, to 12-22-1968, that (I) (we) lost saw the deceased alive on 12-22-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Lilia C. Baldonado				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-22-68		
22d. PHYSICIAN'S NAME (Type) Lilia C. Baldonado M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-26-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd. - 21206				ADDRESS		25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <b>IGNATIUS ALOYSIUS DEWEY</b>					2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>Dec 8</b> 19 <b>68</b>		2b. HOUR <b>7:30</b> M		
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>27 Feb 1911</b>	6. AGE (In years last birthday) <b>57</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD <b>Dec 8</b> Year <b>1968</b>		2d. HOUR <b>9:30</b> M	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Parkville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3014 Taylor Ave</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Assemblyman Fisher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Body Co</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>3014 Taylor Ave</b>		
14. FATHER'S NAME First <b>John</b> Middle <b>A</b> Last <b>Dewey</b>			15. MOTHER'S MAIDEN NAME First <b>Susan</b> Middle <b>Malchitsky</b> Last <b>Malchitsky</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>169-18-4434</b>		17. INFORMANT <b>Mrs Viola Dewey</b>		ADDRESS <b>Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>athero sclerotic Cordeis Vascular</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4221</b> (b) <b>Dissecting</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dissecting</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Unk -</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>None Known.</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John C. Hyle</b>			M.D. <b>JOHN C. HYLE</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12-8-68</b>	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county) <b>7527 Bala Rd Baltimore</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b>			ADDRESS <b>Baltimore, Maryland</b>			25a. REC'D BY REGISTRAR <b>DEC 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Items 5, 6, & 7 Film 408  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
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CERTIFICATE OF DEATH

17016

1. DECEASED-NAME (Type or print) <b>Wenona</b>		First <b>Disney</b>		Last		2a. DATE OF DEATH <b>Dec.</b> Month <b>24</b> Day <b>68</b> Year		2b. HOUR M	
3. SEX <b>F.M.</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 14, 1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b>		Md.	
10. CITY OR TOWN OF DEATH <b>Randallstown Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>9202 Turnbull Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9202 Turnbull Rd. 21133</b>	
14. FATHER'S NAME First <b>First</b> Middle <b>Middle</b> Last <b>Last</b>		15. MOTHER'S MAIDEN NAME First <b>First</b> Middle <b>Middle</b> Last <b>Last</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Multiple CVA's</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>65</b> to <b>Dec 24</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Apr. 4</b> , 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John Danell</b>		DEGREE <b>John Darrell</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-24-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>John Darrell</b>		ADDRESS <b>Randallstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Dec. 27, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Gwyn Oag Ave. Balto Co; Md.</b>			
24. FUNERAL DIRECTOR <b>Loring, yers, 8728 Liberty Rd. Randallstown, Md</b>		ADDRESS <b>21133</b>		25a. REC'D BY REGISTRAR DAY <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17006

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17017

1. DECEASED-NAME (Type or print) First Middle Last GERTRUDE ERNA DITZELL			2a. DATE OF DEATH Month Day Year 12 16 1968			2b. HOUR 1:36 aM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH July 12, 1890		6. AGE (In years last birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4410 Valley View Ave.		14. FATHER'S NAME First Middle Last ? Jentsch		15. MOTHER'S MAIDEN NAME First Middle Last ? Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 215-50-3209		17. INFORMANT Address Raymond C. Ditzell, Jr. 1650 Gleneagle Rd 12			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete atrio-ventricular block</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443x</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13, 1968</u> , to <u>12/16, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/16 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles C. Brown, M.D.</u>						22c. DATE SIGNED 12/16/68	
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D.						22e. ADDRESS Greater Baltimore Medical Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/19/1968		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Eugenia R. Seitz 5209 York Rd. Balto. Md. Seitz Funeral Home 21212				25a. REC'D BY REGISTRAR DATE DEC 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

17071

RECEIVED

2000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) <i>Howard H. Dobbs</i>			First Middle Last			2a. DATE KNOWN OF DEATH MATED <i>December 8 1968</i>			2b. HOUR <i>5:45</i> M.			
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>July 31, 1889</i>	6. AGE (in years lost in day) <i>79</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD <i>December 8 1968</i>		2d. HOUR <i>5:45</i> M.		
7a. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.						
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Joseph's Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Commission Merchant</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Washfield &amp; Co</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>3 Maple Avenue</i>			
14. FATHER'S NAME <i>William Dobbs</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>Bennetta Dobbs</i>			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>216-10-9922</i>			17. INFORMANT <i>Mrs. Elizabeth Stitz-Stevensville, Md.</i>			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4109</i> IMMEDIATE CAUSE (a) <i>Suprarenal Edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>12 Hrs</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 Hrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>			EXAMINER'S NAME (Type) <i>Charles F. O'Donnell, M.D.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <i>12/18/68</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>12-21-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>				
24. FUNERAL DIRECTOR <i>John C. Miller Inc. - 4415 Belair Rd. - 21206</i>						25a. REC'D BY REGISTRAR DATE <i>DEC 23 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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6001 7 0 730

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>17008</div> <div> <div>17019</div> <div> <div>17008</div> <div>17019</div> </div> </div>										
1. DECEASED-NAME (Type or Print) <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div>Robert Edward Dooms, Sr.</div>						2a. DATE KNOWN OF ESTI- DEATH MATED <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>December 25 1968</div>		2b. HOUR <div> <div>Hour</div> <div>Minute</div> </div> <div>10 AM</div>		
3. SEX M.	4. RACE W.	5. DATE OF BIRTH 2/5/1912	6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>December 25 1968</div>		2d. HOUR <div> <div>Hour</div> <div>Minute</div> </div> <div>10 AM</div>		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 210 Maryland Ave.			12a. USUAL OCCUPATION (Kind of work done during 1 week preceding death) Auto Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Service Station		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 210 Maryland Ave.	
14. FATHER'S NAME First Middle Last John H. Dooms				15. MOTHER'S MAIDEN NAME First Middle Last unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-03-3603		17. INFORMANT ADDRESS Inez F. Dooms. same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				<div> <div>Charles F. Donnell</div> <div>M.D.</div> </div>				22b. DATE SIGNED 12/26/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/27/68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.				ADDRESS		25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

15018

TECHNICAL EXAMINER'S CERTIFICATE OF DEATH

15002

FOR STATE  
HEALTH DEPT.

Room 21. Street. Room 21.

S/S/1112

U.S.A.

and a separate service station

S/O. and a separate service station

Room 21.

Belgium. Belgium.

Room 21.

21-3-1112

Room 21.

British

12/7/50

Emergency Relief Committee

General J. Noel Inc. Relief. B.

15002

15002

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17029

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17020

1. DECEASED-NAME (Type or print) First Middle Last ANNE DORSEY			2a. DATE OF DEATH Month Day Year Dec 9 1968			2b. HOUR 10:45 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH July 26, 1920		6. AGE (In years last birthday) 48 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Co. Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 803 Beaverbank Ct.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) At Home		12b. KIND OF BUSINESS OR INDUSTRY *****	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 803 Beaverbank Ct.							
14. FATHER'S NAME First Middle Last Frank Grieb			15. MOTHER'S MAIDEN NAME First Middle Last Anna Patzwall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) ***** 217-09-1566		17. INFORMANT Address Family records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory paralysis</u> 340X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 12 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 345X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>63</u> , to <u>Dec 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Richard Fravel</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) C. Richard Fravel M.D.				22e. ADDRESS Sun Life Buldg.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/13/68		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City or Town) (County) (State) Balto. Co Md.	
24. FUNERAL DIRECTOR ADDRESS C.F. EVANS & SON 8802 Harford road				25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
30M REV. 1-78

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Emma			Dowdell (Dowell)			December 6, 1968		10:45 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
female		Negro		April 14, 1894		74 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Georgia		U. S.				Baltimore		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.					Balto.		YES <input type="checkbox"/> NO <input type="checkbox"/>		147 North Monastery Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Will Peterson			Harriett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
					Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Pulmonary embolism										
4129 DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure										
(b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4221 Azotemia - Decubitus ulcers										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from Sept. 20, 19 68, to Dec. 6, 19 68, that (I) (we) last saw the deceased alive on Dec. 6, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Diomidis Pirovolidis								22c. DATE SIGNED 12-6-68		
22d. PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.								22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		12-10-68		Arbutus Memorial Pk. Baltimore, Maryland						
24. FUNERAL DIRECTOR ADDRESS Morton & Dyett Funeral Homes, Inc. 1701 Laurens St., Balto., Md. 21217						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
						DATE FC 9 1968		J. Charles Judge		

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17011

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17022

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
JULIA VICKERS DOWELL						DEATH MATED <input checked="" type="checkbox"/>			19			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
female		white		2-28-1914		54 YRS.		MONTHS DAYS		HOURS MIN		Month Day Year		10:30 A.M.	
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH			
Maryland				U.S.A.								Baltimore Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Timonium				420 Fox Chapel Road DRIVE				Housewife				Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland				Baltimore				Timonium				420 Fox Chapel Road DRIVE			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
Albert Curtis Bowersock				Mildred Naudine Crawford											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
No				217-50-1445				Mr. David L. Dowell 112 Belmore Road 21093							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Endocarditis, Inactive</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>414X</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Werner J. Spitz</u>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				Werner J. Spitz, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				12/24/68			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				12-27-1968				Dulaney Valley Memorial				Cockeysville, Maryland			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson				1050 York Rd. 21204				DEC 27 1968				Charles Judge			

17023

MEDICAL EXAMINING BOARD OF PENNSYLVANIA

17023

FOR STATE  
HEALTH DEPT

838 7 9 3 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17012		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17023	
Item 5 FilmG408 1/10/69 ts					
1. DECEASED-NAME (Type or print) First Middle Last <b>THERESA MARIE DOYLE</b>			2a. DATE OF DEATH 12 Month 28 Day 68 Year		2b. HOUR 3:15 PM
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>JULY 26, 1893</b>		6. AGE (In years last birthday) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Canada</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE Co.</b> Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CEN.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>924 Dunellen Dr. 21204</b>	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. W. J. Lane 924 Dunellen Dr. #21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>12-26</b> , 19 <b>68</b> , to <b>12-28</b> , 19 <b>68</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>December 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.					
22b. SIGNATURE <i>Rudiger Breitenecker</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>12-29-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Rudiger Breitenecker M.D.</b>				22e. ADDRESS <b>6701 N. Charles St. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/31/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Hood Cem.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Brookline, Mass</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Wm. E. Johnson 8521 Loch Raven Blv. #21204</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

17023

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/69

<div>17013</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print) First Middle Last ROMAN J. DUMBROWSKI - DOMPKOWSKI OR DABROWSKI						20. DATE OF DEATH Month Day Year DECEMBER 9, 1968					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH OCTOBER 16, 1886		6. AGE (In years lost birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			Md.		
10. CITY OR TOWN OF DEATH FORT HOWARD, MD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOSPITAL VETERANS ADMINISTRATION			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SHOEMAKER			12b. KIND OF BUSINESS OR INDUSTRY SHOE SHOP		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3437 CLIFT MONT AVE	
14. FATHER'S NAME First Middle Last THOMAS DOMPKOWSKI				15. MOTHER'S MAIDEN NAME First Middle Last ALEXANDRA UNK.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES				16b. SOCIAL SECURITY NO. 213 34 1975		17. INFORMANT Address CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 493X											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from 8/12/68, 19__, to 12/9/68, 19__, that (X) (we) last saw the deceased alive on 12/9/68, 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (did not) view the body after death.											
22b. SIGNATURE V. Chitraplee				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 12 9 68			
22d. PHYSICIAN'S NAME (Type) VADHANA CHITRAPLEE, M.D.				22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-12-68		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY'S CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR WM FIALKOWSKI FUNERAL HOME, 2007 EASTERN AVE, BALTO, MD				25a. REC'D BY REGISTRAR DEC 12 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10-60)  
30M REV. 11-60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18526

1. DECEASED-NAME (Type or print) First Middle Last <b>Earl Vincent Dube</b>			2a. DATE OF DEATH Month Day Year <b>Dec. 12 1968</b>			2b. HOUR <b>3:45 AM</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-6-00</b>		6. AGE (in years last birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <b>USA Rhode Island</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County, Md.</b>							
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Restaurant Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2015 North Ave</b>					
14. FATHER'S NAME First Middle Last <b>William A. Dube</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Raddigan</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-22-2787</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Pulmonary Tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>② Broncho Pleural fistula, Tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>③ Cor pulmonale, decompensated.</b> 011.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>④ Emphysema, obstructive</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>					
								<b>2 yrs.</b>					
								<b>1 yr.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>7-20</b> , 19 <b>67</b> , to <b>12-12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec. 12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22b. SIGNATURE <b>W Newcomer</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-12-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		22e. ADDRESS <b>Mount Wilson, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cmts</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>							
24. FUNERAL DIRECTOR <b>Newell Funeral Home, Baltimore, Md.</b>		ADDRESS <b>D. &amp; N.</b>		25a. RECEIVED BY REGISTRAR <b>JAN 23 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

10320

RECORDS OF DEATH

1901

Salisbury County

1901

1901

Records, 1901, Salisbury County



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17015					17025					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last ANNA ARMSTRONG DUNLAP					Month Day Year 12 19 68			1:30 P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
FEMALE		CAUCASIAN		OCT. 22, 1901		67 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNA		BALTIMORE MD				BALTIMORE Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
DUNDALK			2638 LIBERTY PKWY			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.			BALTIMORE		DUNDALK		YES		2638 LIBERTY PKWY.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
SAMUEL ARMSTRONG				MARY WHITEMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO				216-32-2847		A. JEANE ZACIERKA AS IN #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident										
4120 DUE TO, OR AS A CONSEQUENCE OF (b) HCD										
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
443X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 3/24, 19 68, to 12/19/68, that (I) last saw the deceased alive on 12/19/68, 19, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.				22c. DATE SIGNED		
Theo C Patterson								12/20/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
THEO C PATTERSON				2427 Wendell				21212		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		12/23/1968		OAK LAWN		BALTIMORE CO., MD.				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
W. Smith Bradley, Hester, MD				DEC 23 1968		James Judge				

MEDICAL CERTIFICATION

1

17022

17022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17016										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17026	
Item 13 Film 408 1/13/69 kk										CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>ELLA MAY DYE</b>					2a. DATE OF DEATH <b>12</b> Month <b>31</b> Day <b>68</b> Year					2b. HOUR <b>M</b>											
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>5-7-1891</b>			6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.												
10. CITY OR TOWN OF DEATH <b>COCKEYSVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MASONIC HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>COCKEYSVILLE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3913 Falls Rd.</b>													
14. FATHER'S NAME First <b>GEORGE</b> Middle <b>ESLEIN</b> Last <b>BELL</b>			15. MOTHER'S MAIDEN NAME First <b>CATHERINE</b> Middle <b>BELL</b> Last <b>BELL</b>																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>212-07-42513</b>			17. INFORMANT <b>Masonic Home Records</b> Address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma Breast.</b> <b>174x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Adenocarcinoma Breast and Uterus.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>174x</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b> <b>7 YRS.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>170x</b>																					
19a. DATE OF OPERATION <b>1961</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Adenocarcinoma Breast.</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1</b> , 19 <b>68</b> , to <b>Dec 31</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec. 31</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.																					
22b. SIGNATURE <b>Carl F. Benson MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (Type) <b>Carl F. Benson MD</b>										22e. ADDRESS <b>3111 York Rd. Balto. Md 21212</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>JAN 3, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>YOPLAK GROVE</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTO. CO. MD</b>												
24. FUNERAL DIRECTOR <b>Wm Cook-Brooks Townsm</b> ADDRESS <b>108 York Rd Townsm. Md 21204</b>										25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17017										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17027																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH																																							
ARTHUR										NMN										ECKHARDT										DEC Month 31 Day 68 Year										12 HOURS 5 MIN																			
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
MALE										White										Feb. 1, 1892.										76 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										USA																				BALTIMORE										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
BALTIMORE										OR. BALTO. MED. CENTER										Clothier																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
Md.																				Baltimore										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										2805 Overland Avenue																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
Gusta										Eckhardt										Minna										Ninehart																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
No										(If yes give war or dates of service)										215-09-1795A										Mrs. Lillian M. Eckhardt										(Same)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										LOBAR PNEUMONIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
481X										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) BRONCHO PNEUMONIA																																																	
										DUE TO, OR AS A CONSEQUENCE OF																																																	
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
491X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 12-20, 19 68, to 12-31, 19 68, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Gregorio B. Pastor										12-31-68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
GREGORIO PASTORFIDE, MD.										6701 N. CHARLES ST. BALTO. MD 21204																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										1/3/69.										Baltimore Cemetery										Baltimore, Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Leonard J. Ruck, Inc. Balto. Md. 21214																				JAN 2 1969										Charles Judge																													

1003

MINISTRY OF HEALTH

1003

REPORT

NAME

DATE

AGE

SEX

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

SEX

REPORTED BY

DATE

LOCATION

SEX

REPORTED BY

DATE

LOCATION

LOCATION

*Handwritten signature*

REPORTED BY

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR		
Bernard			- EDMONDS			Month Day Year			12 3 1968 4:30 <sup>A</sup>		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	Negro	9/20/59	9 YRS.			Month Day Year			12 3 1968 4:30 <sup>A</sup>		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wash., D.C.		U.S.A.				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Owings Mills			Rosewood State Hospital			Dependent			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Prince Geo.			District Heights			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
First Middle Last			First Middle Last			2101-71st Avenue					
Jasper Lee Edmonds			Mina - Swint								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			none			Rosewood Records, Owings Mills, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest due to Aspiration of Bronchial</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Secretions. Traumatic Encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Contusion. Convulsive Disorder due to B.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
7/17/65			Trepines and Tracheostomy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			7 14 <sup>19</sup> 65			Car Accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
						Virginia?					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
D. D. Caples			M.D.			12/3/68					
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)					
D. D. Caples, M.D.			Reisterstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			12/7/68			Harmony Memorial Park			Maryland		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Stewart Funeral Home-4001 Benning Road						DEC 6 1968			J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17019

CERTIFICATE OF DEATH

17029

1. DECEASED-NAME (Type or print) First <b>ADOLPH</b> Middle <b>WILLIAM</b> Last <b>EIRING</b>			2a. DATE OF DEATH Month <b>DECEMBER</b> Day <b>23</b> Year <b>1968</b>		2b. HOUR <b>5:10A</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>MARCH 23, 1895</b>		6. AGE (In years last birthday) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE,</b> Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CONTINENTAL CAN CO.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>2124 BANK STREET #21231</b>	
14. FATHER'S NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-03-3720</b>		17. INFORMANT <b>ROSE EIRING 2124 BANK ST</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EPIDERMOID CARCINOMA of the RIGHT LUNG</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163x</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 23, 1968</b> , to <b>December 23, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 23, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>Eugenio Antonio</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>December 23, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Eugenio Antonio, M.D.</b>		22e. ADDRESS <b>7620 York Road Towson, Md. #21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEM.</b>	
23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>					
24. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC 401 S. CHESTER ST</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

THE STATE OF TEXAS,  
COUNTY OF \_\_\_\_\_

DO COME before me, the undersigned, a Justice of the Peace for and in and for the County of \_\_\_\_\_, State of Texas, the following parties to the following cause:

VS.

\_\_\_\_\_

DEPT. 4 1902

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17020

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17030

1. DECEASED-NAME (Type or Print) First Robert Middle H. Last Ellingson			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 19 OF ESTI- DEATH MATED <input type="checkbox"/>			2b. HOUR M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7/18/11	6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month December 14 1968			2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1766 Melbourne Road			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Conductor, Patapsco & Back River		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1766 Melbourne Rd.
14. FATHER'S NAME First Middle Last Hans Ellingson			15. MOTHER'S MAIDEN NAME First Middle Last Lena Bernstein			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b. SOCIAL SECURITY NO. 215-07-6259			17. INFORMANT (Wife) Mrs. Mary C. Ellingson, 1766 Melbourne Rd.			ADDRESS Dundalk, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> 3724 Dundalk Ave. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 16, 1968 M.D. ADDRESS (Street, city, town, or county) Dundalk, Md. 21222									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/17/68		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17021

## CERTIFICATE OF DEATH

17031

1. DECEASED-NAME (Type or print) <b>HYMAN</b>			First Middle Last			2a. DATE OF DEATH Month <b>DECEMBER</b> Day <b>2</b> Year <b>1968</b>			2b. HOUR <b>9:20</b> P.M.		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>12-28-1891</b>			6. AGE (in years last birthday) <b>76</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>M ILFORD MANOR NURSING HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TAILOR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>UNKNOWN EPSTEIN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>MRS. ANNE BASS, 5715 JONQUIL AVENUE #21215</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic Heart Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>no</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>no</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200</b> <b>none</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 29</b> , 19 <b>65</b> , to <b>Dec 2</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec 2</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Manuel Levin</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>12/3/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN</b>			22e. ADDRESS <b>6101 PARK HEIGHTS AVENUE</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12-3-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>DEC 6 1968</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1001

1001-1001

Arthur White Hall Brown

me  
you  
me

X

March 1908  
X  
12/1/08

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17022										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17032																			
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR									
MARIE										E. EVERETT										DECEMBER Month 3, Day 1968										4:00A.M.									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.														
FEMALE					WHITE					FEBRUARY 24, 1896					72 YRS.																								
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH										Md.														
MARYLAND					U.S.A.										BALTIMORE																								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																								
TOWSON					ST. JOSEPH HOSPITAL					HOMEMAKER					HOME																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER																			
MARYLAND										BALTIMORE										3301 NORMAN AVE. #21213																			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																																		
First Middle Last					First Middle Last																																		
PETER GRANLUND					BRIDGET McDEVITT																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																													
No										Mrs. Davis Hargan - 3301 Norman Ave																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas with extensive metastasis</u>																																							
157.9 DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																																							
(b) DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
157X																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from November 16 1968, to December 3 1968, that (I) (we) lost saw the deceased alive on December 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE															22c. DATE SIGNED																								
Ines Cilliani, M.D.															12/3/68																								
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS																								
															7620 York Rd., Towson, Md. 21204																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																								
BURIAL					12-6-68					NEW CATHEDRAL CEM.					BALTO., Md.																								
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE														
Hester Miller - 2334 Lippman St															DEC 6 1968										Johnas Judge														

11033

CERTIFICATE OF BIRTH

11033



DEC 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Charles J. Fabiszak					Dec. Month 5, Day 1968.		3:30 P.M.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male	White		Oct. 8, 1920.		48 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		8609 Drumwood Road		Accountant--Roofing Products Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8609 Drumwood Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Joseph Fabiszak		Mary Seifert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes, give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		215-14-9802		Mrs. Margaret C. Fabiszak		(Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION									
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE								2 YRS	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201 DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1966, to Dec 5, 1968, that (I) (we) last saw the deceased alive on 9/7/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
William A. Pilsbury						12-6-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
William A. Pilsbury		Towson Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/9/68.		Dulaney Valley Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Balto. Md. 21214						DEC 6 1968		[Signature]	

Charles	J.	1900	1900
White	Oct. 8, 1900	1900	1900
Married	1900	1900	1900
London	1900	1900	1900
1900	1900	1900	1900
1900	1900	1900	1900
1900	1900	1900	1900
1900	1900	1900	1900

17024

## CERTIFICATE OF DEATH

17034

1. DECEASED-NAME (Type or print) <b>Rebeckah</b>		First <b>Mozell</b>		Middle <b>Featherston</b>		Last <b>N</b>		2a. DATE OF DEATH <b>12</b> Month <b>18</b> Day <b>68</b> Year				2b. HOUR <b>11</b> AM	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-23-89</b>				6. AGE (In years lost birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.							
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto Co Gen Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Certified Public Acc.</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Self-employee</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>14 Church Road</b>					
14. FATHER'S NAME First <b>Lawrence</b>		Middle <b>Wilson</b>		Last <b>Agnes</b>		15. MOTHER'S MAIDEN NAME First <b>Scott</b>		Middle <b>Agnes</b>		Last <b>Scott</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>2150-4925</b>		17. INFORMANT <b>Spouse Thomas Featherston</b>				Address <b>11 Church Rd own m m lls</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>203X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple Myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8 months</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>203X</b>													
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>None</b>									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1968</b> , to <b>Dec 18, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Martin J. Feldman MD</b>		22c. DATE SIGNED <b>12-18-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Martin J. Feldman MD</b>		22e. ADDRESS <b>Cherry Hill Rd Pasterstown MD 21136</b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. DATE SIGNED <b>12-18-68</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>Dec. 19, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		23d. LOCATION (City or Town) <b>Baltimore City</b>		(County)		(State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Loring Byers Chaple</b>		ADDRESS <b>8728 Liberty Road</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17025

CERTIFICATE OF DEATH

17035

1. DECEASED-NAME (Type or print) First Middle Last <b>HORACE PRICE FERRELL</b>			2a. DATE OF DEATH Month Day Year <b>12 26 68</b>			2b. HOUR <b>7:30p</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAU.</b>		5. DATE OF BIRTH <b>8-16-17</b>		6. AGE (In years lost birthday) <b>51</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE, COUNTY</b> Md.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT BALTO. MED. CENTR.</b>		12a. USUAL OCCUPATION (Kind of work done during last working life season if retired.) <b>ELECTRIC INSPECTOR</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>USA</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>215 Linhigh Avenue</b>							
14. FATHER'S NAME First Middle Last <b>PRITCHARD FERRELL</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>LILLIAN CROUCH</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>231-12-1598</b>		17. INFORMANT <b>Leona P. Ferrell</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>203X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>203X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 19 68</b> , to <b>12/26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. Mussiva</b>						22c. DATE SIGNED <b>12-26-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. MUSSIVA</b>						22e. ADDRESS <b>GREAT BALTO. MED. CENTR.</b>	
23a. BURIAL, CREMATION, REINTERMENT (Type)		23b. DATE <b>12/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Road</b>				25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1962

THE STATE OF TEXAS

COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this day personally appeared

JOHN P. WATKINS, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this 1st day of January, 1962.

JOHN P. WATKINS, Notary Public for the State of Texas

NOTARY PUBLIC

WATKINS

JOHN P. WATKINS, Notary Public for the State of Texas

NOTARY PUBLIC

JOHN P. WATKINS, Notary Public for the State of Texas

JOHN P. WATKINS, Notary Public for the State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17026										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17036									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
ARTHUR H. ope FILANDER										Month 12 Day 30 Year 1968										11:40a									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Male			Caucasian			Feb. 4, 1904			64 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Penna.			U.S.A.						Baltimore Md.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Towson, Md.					Greater Balto. Med. Center					Engineer																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Maryland					Baltimore					21212					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					720 Anneslie Road									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Andrew Filander					Sabina					?????????																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
No					290-07-2074					Mrs. Corrine H. Filander, Same as # 13																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) 485X Acute bronchopneumonia, bilateral																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
491X Diffuse pulmonary emphysema																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 12/30, 1968, to 12/30, 1968, that (I) (we) last saw the deceased alive on 12/30 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE John E. Adams										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 12/30/68														
22d. PHYSICIAN'S NAME (Type) John E. Adams, M. D.										22e. ADDRESS Greater Baltimore Medical Center																			
23a. BURIAL CREMATION					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Jan. 2, 1969					Dulaney Valley Mem. Mausoleum, Cockeysville, Maryland																			
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204										DATE JAN 3 1969					Charles Judge														

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17027

CERTIFICATE OF DEATH

17037

1. DECEASED-NAME (Type or print) <b>Angelina</b>		First Middle Last <b>FIOROLI</b>		20. DATE OF DEATH Month <b>12</b> Day <b>16</b> Year <b>1968</b>		2b. HOUR <b>7:40</b> A M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>January 10, 1903</b>		6. AGE (In years lost birthday) <b>65</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>27 Cockpit St.</b>		14. FATHER'S NAME First Middle Last <b>BUCCI</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>?</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>UNK</b>		16b. SOCIAL SECURITY NO. <b>4109</b>		17. INFORMANT <b>ARTHUR FIOROLI</b>		Address <b>ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction sec. to</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) <b>coronary artery thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pulmonary infarction</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/1/</b> , 19 <b>68</b> , to <b>12/16/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/16/</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Christina Feliciano</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/16/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Christina Feliciano, M.D.</b>				22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/19/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STASIS LAUS</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>				ADDRESS <b>300 MACE</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 19 1968</b>	
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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100-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17028										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17038									
Item 10 Film 408 1/6/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First <b>Eva</b>					Middle <b>E</b>					Last <b>Fleischmann</b>					2a. DATE OF DEATH					2b. HOUR				
																				Month <b>12</b> Day <b>24</b> Year <b>68</b>					9:30 P				
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years lost birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.				
Female					White					12-31-95					72 YRS.					MONTHS					DAYS				
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md.									
Maryland					USA										Baltimore														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Baltimore					8020 Ridgely Oak Rd.					Housewife					Home														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
Md.					Balto.															21234									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					Address																			
First Middle Last					First Middle Last																								
Nicholas					Sebour					Johanna Siefert																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
No										Mrs. Louis Steinbacker, 8020 Ridgely Oak Rd.					21234														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>																													
2509 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c) <b>DIABETE MELLITUS</b>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
260X																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No. City or Town County State														
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																													
22a. I certify that (I) (this hospital) attended the deceased from <b>November 19, 1968</b> , to <b>Dec 24, 1968</b> , that (I) (we) lost the deceased alive on <b>Dec 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE															22c. DATE SIGNED														
<b>Larry G. Tilley MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															<b>12-26-68</b>														
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS														
<b>Dr. L.G. Tilley</b>															<b>1713 Taylor Avenue, Balto. Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
<b>Burial</b>					<b>12-28-68</b>					<b>Sacred Ht. Jesus</b>					<b>Balto. Co. Maryland</b>														
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
ADDRESS															DATE														
<b>W.E. Johnson</b>															<b>8521 Loch Raven Blvd. 21204</b>					<b>DEC 30 1968</b>									
																				<b>Charles Judge</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
1. DECEASED-NAME (Type or print)		First NINA		Middle V		Last FORD		2a. DATE OF DEATH Month Day Year DECEMBER 9 1968		2b. HOUR 10 P. M.
3. SEX F		4. RACE W		5. DATE OF BIRTH FEBRUARY 26, 1884		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) CONNECTICUT		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.				
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHADY NOOK NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN HALETHORPE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1717 FAIRVIEW AVE 21227		
14. FATHER'S NAME First Middle Last WILLIAM H. VAN KEURON				15. MOTHER'S MAIDEN NAME First Middle Last MINNIE GIBBS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 027-09-1385		17. INFORMANT Address RUTH F. WHEELER 1717 FAIRVIEW AVE. 21227						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months +										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 10</u> , 19 <u>68</u> , to <u>Dec. 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John A. Nesbitt, Jr.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-10-68				
22d. PHYSICIAN'S NAME (Type) Dr. John A. Nesbitt, Jr.		22e. ADDRESS 1009 Frederick Road, Balto. Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-12-68		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City Balto. Md.				
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 days after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
17030  
17040  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) W. ROBERT FRANK			2a. DATE OF DEATH Month 21, Day 1968			2b. HOUR 11:59 P					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEBRUARY 21, 1913		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE, Md.					
1D. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired) Major - BALTO. CITY POLICE DEPT.		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Northhill Rd 979 Northhill Rd. #21218			
14. FATHER'S NAME First Middle Last E. Ross Franck			15. MOTHER'S MAIDEN NAME First Middle Last Alice V McLaughlin								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 213-01-6355			17. INFORMANT Mrs Anna H Franck			Address Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4301</u> (b) <u>Thrombotic Occlusion of Right Circumflex Branch</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Compensative Heart Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Compensative heart failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>December 21, 1968</u> , to <u>December 22, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ines Cilliani</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED December 22, 1968		
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.						22e. ADDRESS 7620 York Road Baltimore, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/26/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland				25a. BY REGISTRAR DATE DEC 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If my delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film 08  
1/6/69 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
17031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17041

1. DECEASED-NAME (Type or Print) Elizabeth			First Middle Last Freitag			2a. DATE KNOWN OF DEATH Month Day Year December 22 1968			2b. HOUR 6.25 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10-2-84		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6308 Belair Rd. 6000 Belair Ave., L.P.A.P.			
14. FATHER'S NAME Julius			First Middle Last Franz			15. MOTHER'S MAIDEN NAME Christina			First Middle Last Barth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-46-2457			17. INFORMANT Mrs. Helen Fak, 5916 Breckenridge Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fracture of Left Hip</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. 3 Weeks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 904.7													
19a. DATE OF OPERATION 12/21/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of Left Hip						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 3 P.M. December 19 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, Item 1B.) Fall in Room.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Nursing Home			21f. LOCATION Street or R.F.D. No. City or Town Bellona Ave. & Belvedere 21212 Baltimore City Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles F. O'Donnell						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 12/22/68				
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/26/68			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.						25a. REC'D BY REGISTRAR DEC 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				

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STANDARD INDUSTRIAL PAPER CO. (INCORPORATED)  
NEW YORK, N. Y.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
1. DECEASED-NAME (Type or print)		First <b>Kathryn</b>		Middle <b>M.</b>		Last <b>French</b>		20. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>1968</b>		2b. HOUR <b>M</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 31, 1878</b>		6. AGE (In years last birthday) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS <b>4</b> DAYS <b>1</b>		IF UNDER 24 HRS. HOURS <b>1</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Balto. CO. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		Md.		
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8710 Wendell Ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>never worked</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8710 Wendell Ave</b>		
14. FATHER'S NAME First <b>Andrew</b> Middle <b>French</b> Last <b>French</b>		15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Swope</b> Last <b>Swope</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219 50 9708T</b>		17. INFORMANT Address <b>Mrs. Thomas F. Bufter 6523 Loch Hill Rd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>491X Adipose tissue necrosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>485X</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 3</b> , 19 <b>68</b> , to <b>Dec 19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec 19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Sebastian Russo</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Dec 20 1968</b>
22d. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO MD</b>		22e. ADDRESS <b>5017 Harford Rd Md</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/23/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR <b>Mitchell Wiedefeld Home</b>		ADDRESS <b>6500 York Rd.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>LESTER</b>			First <b>J</b> Middle <b>FRIEDMAN</b> Last			2a. DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>68</b>			2b. HOUR <b>11:30</b> AM		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>12-19-94</b>			6. AGE (In years last birthday) <b>73</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON MD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>159 HOME ST. E. JEFFERSON</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Engineer Naval</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Aeronautical</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>A.A.</b>			13c. CITY OR TOWN <b>Edgewood</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>Box 319 D</b>			14. FATHER'S NAME First <b>FRANK</b> Middle <b>FRIEDMAN</b> Last			15. MOTHER'S MAIDEN NAME First <b>Linda</b> Middle <b>Bachmann</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>220-44-2396</b>			17. INFORMANT <b>Genora white Bowie, Md</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CYCLINOMA OF POSTERIOR 141.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1/3 OF tongue</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>141.8</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/4/68</b> , to <b>12/11/68</b> , that (I) (we) last saw the deceased alive on <b>12/11/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles F. Orndorff</b>						22c. DATE SIGNED <b>12/11/68</b>					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <b>7501 York Rd - Towson 21207</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec 16, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Spring Grove Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Cincinnati Hamilton Ohio</b>		
24. FUNERAL DIRECTOR <b>F. Gassh's Sons</b> ADDRESS <b>Hyattsville, Md.</b>						25a. REC'D BY REGISTRAR <b>DEC 16 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION

17003

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>17034</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17044</div>											
1. DECEASED-NAME (Type or print) First Middle Last <b>IRVIN MELVIN FROCK</b>						2a. DATE OF DEATH Month Day Year <b>DECEMBER 7, 1968</b>			2b. HOUR <b>2:25 PM</b>		
3. SEX <b>MALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH <b>APRIL 20, 1900</b>			6. AGE (In years lost birthday) <b>68 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SECURITY GUARD</b>			12b. KIND OF BUSINESS OR INDUSTRY <b></b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>3831 LYNDALE AVENUE</b>			14. FATHER'S NAME First Middle Last <b>STEPHEN FROCK</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNIE SWEN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) <b>WW I</b>			16b. SOCIAL SECURITY NO. <b>213 05 7791</b>			17. INFORMANT Address <b>CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b> <b>2022</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MALIGNANT LYMPHOMA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>P</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2002</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>10/30/68</b> , 19__, to <b>12/7/68</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/7/68</b> , 19__, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I) (we) did not</del> view the body after death.											
22b. SIGNATURE <b>Neilon Neilson</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12 7 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M.D.</b>						22e. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12/11/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BALTO NATIONAL CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR ADDRESS <b>ULLIRICH FUNERAL HOME, 4210 BELAIR RD, BALTO, MD</b>						25a. REC'D BY REGISTRAR <b>DEC 11 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Film G108  
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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17045

1. DECEASED-NAME (Type or Print) <b>GROVER EUGENE FUNKHOUSER</b>			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>12-25 1968</b>			2b. HOUR <b>M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>11/27/28</b>	6. AGE (In years last birthday) <b>40</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year <b>December 25 1968</b>	2d. HOUR <b>2:30 PM</b>
7a. BIRTHPLACE (State or foreign country) <b>MOREFIELD, W.VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b> Md.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore County General Hosp. SERVICEMAN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>Ellicott City</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>108 Old Frederick Rd.</b>
14. FATHER'S NAME <b>LLOYD FUNKHOUSER</b>			15. MOTHER'S MAIDEN NAME <b>EVNICE HOSE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>KOREAN 216-24-1551</b>		17. INFORMANT <b>MRS. RALPH FUNKHOUSER</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia by piece of meat</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>9210</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>12-25 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Choked on piece of meat</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>apartment</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>240 Oella Ave.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>Charles S. Springate</b>		EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>December 26, 1968</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-28-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OLIVET</b>		23d. LOCATION (City or Town) (County) (State) <b>MOOREFIELD, W.VA</b>	
24. FUNERAL DIRECTOR <b>HIGDON BATHAN SLACK</b>		ADDRESS <b>ELICOTT CITY, MD</b>		25a. REC'D BY REGISTRAR <b>DEC 31 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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17036										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17046																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last GERALD THOMAS FURNESS										Month Day Year December 25 1968										1:45 PM																																							
3. SEX Male										4. RACE White										5. DATE OF BIRTH 9-16-05										6. AGE (In years lost birthday) 63 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Vermont										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																													
10. CITY OR TOWN OF DEATH Baltimore										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hartford Steam Boiler Company										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. CITY OR TOWN Balto.										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER 1028 Woodson Rd. #21212																													
14. FATHER'S NAME First Middle Last Moses J. Furness										15. MOTHER'S MAIDEN NAME First Middle Last Umpfired Fitzgerald										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II										16b. SOCIAL SECURITY NO.										17. INFORMANT Wife - Mabel S. Address Same																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> , 19 <u>68</u> , to <u>12-25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-25-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE 										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12-25-68																																							
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.										22e. ADDRESS 7620 York Road, Towson, Md. 21204																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 12/30/68										23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem										23d. LOCATION (City or Town) (County) (State) Baltimore Co																													
24. FUNERAL DIRECTOR J. Heumann										ADDRESS 6067 Bayford Rd										25a. REC'D BY REGISTRAR JAN 2 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													

for

(3)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17047

1. DECEASED NAME (Type or print) <b>MISSA RISSA</b>		Middle <b>Hill</b>		Last <b>GANTER</b>		2a. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>68</b>		2b. HOUR <b>11:55</b> AM	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>7/13/86</b>		6. AGE (In years lost birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		Md.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore County Gen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3612 Cedar Drive</b>	
14. FATHER'S NAME First <b>uk</b> Middle <b>Claudius</b> Last <b>Hill</b>		15. MOTHER'S MAIDEN NAME First <b>uk</b> Middle <b>Unknown</b> Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-16-0770</b>		17. INFORMATION <b>hospital record</b> Address <b>Carl Von Lossberg-3612 Cedar Drive 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-9</b> , 19 <b>68</b> to <b>12-9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Janice D. Pomeroy</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-9-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>RACHELITA TOPAL</b>		22e. ADDRESS <b>BLA...</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>Ellsworth Armacost-4600 Liberty Hgts. Avenue</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>17038</span> <span>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</span> <span>17048</span> </div>									
1. DECEASED-NAME (Type or Print) <u>HELEN</u> First <u>GARCIA</u> Middle <u>GARCIA</u> Last						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>DEC</u> Day <u>25</u> Year <u>1968</u>		2b. HOUR <u>4</u> M <u>PM</u>	
3. SEX <u>F.</u>	4. RACE <u>W.</u>	5. DATE OF BIRTH <u>AUG. 5 1905</u>	6. AGE (in years last birthday) <u>63</u> YRS.	IF UNDER 1 YEAR MONTHS <u>63</u> DAYS <u>63</u>	IF UNDER 24 HRS. HOURS <u>63</u> MIN. <u>63</u>	2c. DATE PRONOUNCED DEAD Month <u>DEC</u> Day <u>25</u> Year <u>1968</u>		2d. HOUR <u>4</u> M <u>PM</u>	
7a. BIRTHPLACE (State or foreign country) <u>MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>BALTIMORE</u> Md.			
10. CITY OR TOWN OF DEATH <u>SENECA PARK</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>558 SENECA PK. RD.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u> COUNTY <u>-</u>				13c. CITY OR TOWN <u>BALTIMORE</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>2328 FLEET ST.</u>	
14. FATHER'S NAME First <u>MICHALSKI</u> Middle <u>?</u> Last <u>?</u>			15. MOTHER'S MAIDEN NAME First <u>?</u> Middle <u>?</u> Last <u>?</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>220-03-8474</u>		17. INFORMANT <u>MRS. ANNA BROWN</u>			ADDRESS <u>558 SENECA PK RD.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4221</u> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <u>4221</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <u>6800 HORNINGTON RD.</u>		City or Town <u>BALTIMORE</u>		County <u>MD.</u> State <u>MD.</u>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>M.B. Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>12/28/68</u>			
EXAMINER'S NAME (Type) <u>MELVIN B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <u>6800 HORNINGTON RD. BALTIMORE MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC. 28, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS CEM.</u>		23d. LOCATION (City or Town) <u>BALTIMORE</u> (County) <u>MD.</u> (State) <u>MD.</u>			
24. FUNERAL DIRECTOR <u>RAYMOND L. KACZOROWSKI</u>				ADDRESS <u>2525 FLEET ST.</u>		25a. REC'D BY REGISTRAR <u>DEC 31 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

17028

17028

Merwin B Davis M.D.

DEC 1 1958

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 14. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17039

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17049

1. DECEASED-NAME (Type or Print) <b>Oliver Wesley Garland</b>			First Middle Last			2a. DATE KNOWN OF DEATH Month Day Year <b>December 2, 1968</b>			2b. HOUR OF DEATH M <b>11:30 AM</b>				
3. SEX <b>Male</b>	4. RACE <b>CAU</b>	5. DATE OF BIRTH <b>Feb 2, 1908</b>	6. AGE (In years last birthday) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>December 3, 1968</b>			2d. HOUR <b>8:30 AM</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.							
10. CITY OR TOWN OF DEATH <b>Essex 21221</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>810 Arncliffe Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Grill Manager</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex 21221</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>810 Arncliffe Rd.</b>				
14. FATHER'S NAME <b>George Garland</b>				First Middle Last				15. MOTHER'S MAIDEN NAME <b>Mary E. Davis</b>				First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>527 01 6332</b>			17. INFORMANT <b>Betty Garland</b>			ADDRESS <b>Same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF <b>HEVD</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>													
19a. DATE OF OPERATION _____				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year _____ HOUR A.M. _____ P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____		21f. LOCATION Street or R.F.D. No. _____				City or Town _____		County _____ State _____			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Theodore Patterson</b> EXAMINER'S NAME (Type) <b>Theodore Patterson, M.D. 3427 Dundalk Ave. Dundalk, Md. 21222</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12/4/68</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Pk.</b>				23d. LOCATION (City or Town) (County) (State) <b>Howard Co., Md.</b>					
24. FUNERAL DIRECTOR <b>James E. Bruzdziński</b>						ADDRESS <b>1407 Eastern Ave. 21221</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

FOR STATE  
FILE NO. 1021

17042

MEDICAL EXAMINER, COUNTY OF DEATH

Oliver Wesley Garland

DOB Feb 2, 1906 60

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USA

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George Garland

23521

23521

23521

Theodore Patterson, 110 23521

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR 1:55 PM		
LESLIE			A. GIBSON			12 28 68					
3. SEX FEMALE			4. RACE White			5. DATE OF BIRTH March 2nd, 1896			6. AGE (In years lost birthday) 72 YRS.		
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Co. Md.		
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CEN.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Balto.			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 4 Upland Road			14. FATHER'S NAME First Middle Last William A. Albaugh			15. MOTHER'S MAIDEN NAME First Middle Last Mary Hall Boblitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. 214-20-6304			17. INFORMANT Mr. David C. Gibson			Address 4 Upland Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Breast with Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>11-09</u> , 19 <u>68</u> , to <u>12-28</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>December 28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Chang-I Lin M.D.</u>			22c. DATE SIGNED 12-28-68			22d. PHYSICIAN'S NAME (Type) Dr. Chang-I Lin M.D.			22e. ADDRESS 6701 N. Charles St. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 12/30/68			23c. NAME OF CEMETERY OR CREMATORY Greenmount			23d. LOCATION (City or Town) (County) (State) Baltimore		
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			25a. REC'D BY REGISTRAR JAN 3 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

1950

UNITED STATES OF AMERICA

IN SENATE, January 10, 1950

REPORT OF THE

COMMISSION

ON THE ACTS AND OMISSIONS OF THE

EXECUTIVE AND LEGISLATIVE BRANCHES

IN CONNECTION WITH THE

ADMINISTRATION OF THE

INTERNAL SECURITY ACT OF 1950

AND THE

INTERNAL SECURITY ACT OF 1950

AND THE

INTERNAL SECURITY ACT OF 1950

AND THE

INTERNAL SECURITY ACT OF 1950

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AND THE

INTERNAL SECURITY ACT OF 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Film 407 12/18/68 **MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

17011

17051

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>119 Glyndon Drive</u>				e. STREET ADDRESS <u>119 Glyndon Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Beulah P. Gill</u>				4. DATE OF DEATH <u>December 5, 1968</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Jan. 11, 1898</u>			
9. AGE (In years last birthday) <u>71</u> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				11b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John L. Tawney</u>				14. MOTHER'S MAIDEN NAME <u>Annie Carver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Family records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinomatosis</u> <u>1519</u> DUE TO (b) <u>Gastric adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>151X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-16</u> , 19 <u>68</u> , to <u>12/4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/4</u> 19 <u>68</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip Bernstein</u>				22b. DATE SIGNED <u>12-6-68</u>			
22c. PHYSICIAN'S NAME (Type) <u>Philip Bernstein, M.D.</u>				22d. ADDRESS <u>112 Chartley Drive, Reisterstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec. 7, 1968</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Grace Falls Road Meth. Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Cockeysville, Md.</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 9 1968</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11/12/1911

1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17042 CERTIFICATE OF DEATH 17052

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Corbett (Monkton P.O.)</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Corbett (Monkton P.O.)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Corbett Road</u>				d. STREET ADDRESS <u>Corbett Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Bessie Elizabeth</u> Middle <u>Gillian</u> Last <u></u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1968</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5, 1884</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Family records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Cardiac Vascular Disease.</u> 4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension - Chronic Congestive failure</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>443X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>63</u> , to <u>Dec 11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 11</u> , 19 <u>68</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert Mueller</u>				22b. DATE SIGNED <u>12/13/68</u>		22c. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR</u>	
22d. ADDRESS <u>PARKTON - Md-21124</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 14, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monkton Methodist Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Monkton, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 14  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
JOSEPHINE			R. P.		GIZINSKI		DECEMBER 11			Day 1968		12:35A
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE		WHITE		JUNE 30, 1900				68		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.
POLAND		U.S.A.				BALTIMORE,						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of year, if even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			ST. JOSEPH HOSPITAL				HOMEMAKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND						BALTIMORE				6616 BELFORD RD. #21206		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First
Anthony			Ruszkiewicz		Magdeline		Klimas					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address				
No			217-01-7133A		Mr Stephen S Gizinski			Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a)												
4129 ARTERIOSCLEROTIC HEART DISEASE												
DUE TO, OR AS A CONSEQUENCE OF												
CONGESTIVE HEART FAILURE												
DUE TO, OR AS A CONSEQUENCE OF												
HEPATOMA												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
4200												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year									
			P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from December 10, 1968, to December 11, 1968, that (X) (we) last saw the deceased alive on DECEMBER 11, 1968 and that in (our) (aur) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
MARCISO LOBO, M.D.												December 11, 1968
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS				
								7620 York Road				Towson, Md. #21204
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			12/14/68		Gardens Of Faith			Baltimore, Maryland				
24. FUNERAL DIRECTOR								ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Leonard J Ruck Inc								Baltimore, Maryland		DATE DEC 11 1968		Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17014

CERTIFICATE OF DEATH

17054

1. DECEASED-NAME (Type or print) <b>LAURA JESSIE GODDARD</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>68</b>			2b. HOUR <b>4:25 P.M.</b>					
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>12-11-10</b>		6. AGE (In years last birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.					
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>2322</b> COUNTY <b>MD.</b> <b>SYDNEY AVE</b>			13c. CITY OR TOWN <b>WESTPORT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2322 Sydney Ave. 21230</b>				
14. FATHER'S NAME First <b>unknown</b> Middle <b></b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Emma May</b> Middle <b>?</b> Last <b></b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO. <b>220-09-6315</b>		17. INFORMANT <b>Dr. Howard A. Hecker</b>			Address <b>2845 Hollins Ferry Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST.</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIOSCLEROTIC HEART DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>17</b> Year <b>68</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b>Woodlawn</b> County <b>MD.</b> State <b></b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>3-38, 1961</b> , to <b>12-17, 1968</b> , that (I) (we) last saw the deceased alive on <b>12-17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>					DEGREE <b></b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-17-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>EVELIO A. FELIPE MD</b>					22e. ADDRESS <b>SPRING-GROVE-STATE-HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/20/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn MD.</b>					
24. FUNERAL DIRECTOR <b>John J. Cowan + Son Inc.</b>					ADDRESS <b>Hollins St. 23rd Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

25971

1952-10-10

1952-10-10

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DEC 3 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17045					17055				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last PAULA GOLD					Month Day Year DEC 9 1968			8:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		2/6/32		36 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE				6726 LONGHILL ROAD		Housewife		AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6726 Longhill Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
MORRIS GINSBERG			MARY SILVERMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			213-28-9791		MR. HENRY H. GOLD, 6726 LONGHILL ROAD #21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2201 INTRA PERITONEAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED HEMORRHAGIC OVARIAN CYST DUE TO, OR AS A CONSEQUENCE OF (c) ANTICOAGULANT THERAPY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 Day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 216X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1950, to 12-9-1968, that (I) (we) last saw the deceased alive on 12-9-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L.F. Awalet					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/9/68		
22d. PHYSICIAN'S NAME (Type) L.F. Awalet					22e. ADDRESS UNIVERSITY HOSP.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		12-10-68		MIKRO KODESH-BETH ISRAEL		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					DEC 10 1968		J. Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17046

CERTIFICATE OF DEATH

17056

1. DECEASED-NAME (Type or print) First Middle Last Samuel V Goldberg			2a. DATE OF DEATH Month Day Year Dec 12 68			2b. HOUR 9 P. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2-22-02		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto Md.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto County General Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GROCERY STORE		12b. KIND OF BUSINESS OR INDUSTRY OWNER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Balto		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 9 Cobblestone Ct.							
14. FATHER'S NAME First Middle Last Victor Goldberg			15. MOTHER'S MAIDEN NAME First Middle Last Bell not known				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 283-10-2354		17. INFORMANT Address MR. BERNARD KLEGER, 8808 ALLENSWOOD ROAD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 Congestive heart failure Acute myocardium infarction							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Multiple Myeloma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov 26, 1967, to Dec 12, 1967, that (I) (we) last saw the deceased alive on Dec 12, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bon Ganan				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/12/68	
22d. PHYSICIAN'S NAME (Type) BOON VARRASIN				22e. ADDRESS Balto. County General Hosp			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-13-68		23c. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR DATE DEC 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

1-1028

THE OFFICE OF THE ATTORNEY GENERAL

1-1028

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DEC 18 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) Anna		First Middle Last R. Goldman		2a. DATE OF DEATH 12 Month 05 Day 68 Year		2b. HOUR a 9:40	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1-30-90		6. AGE (In years lost birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) uk		12b. KIND OF BUSINESS OR INDUSTRY uk	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3508 W. Garrison Ave.		14. FATHER'S NAME First Middle Last n/a		15. MOTHER'S MAIDEN NAME First Middle Last n/a			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) uk		16b. SOCIAL SECURITY NO. uk		17. INFORMANT Mr. Harry Goldman		Address 3513 Spaulding Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> YEARS (c) <u>Arteriosclerotic cardiovascular disease</u> YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-24-68</u> , 19 <u>68</u> , to <u>12-5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Angelita Apiano</u>		DEGREE <u>ANGELITA TORACIO</u>		22c. ADDRESS <u>BC 2A</u>		22e. DATE SIGNED <u>12-5-68</u>	
22d. PHYSICIAN'S NAME (Type)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/6/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Har Sinai Benevolent</u>		23d. LOCATION (City or Town) (County) (State) <u>Roseville Md</u>	
24. FUNERAL DIRECTOR <u>Sylvan S. Spindler Son, Inc</u>		ADDRESS <u>9010 Resurrection Rd</u>		25a. RECD BY REGISTRAR <u>DEC 5 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <span>17018</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>17058</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. DECEASED NAME</b> (Type or print) <b>HESTER E.</b>						<b>2a. DATE OF DEATH</b> December 20 <sup>th</sup> 1968		<b>2b. HOUR</b> 8:45 <sup>P</sup> M			
<b>3. SEX</b> Female		<b>4. RACE</b> White		<b>5. DATE OF BIRTH</b> September 19, 1903		<b>6. AGE (In years last birthday)</b> 65 YRS.		<b>IF UNDER 1 YEAR</b> MONTHS DAYS		<b>IF UNDER 24 HRS</b> HOURS MIN	
<b>7a. BIRTHPLACE (State or foreign country)</b> Maryland		<b>7b. CITIZEN OF WHAT COUNTRY?</b> USA		<b>8. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>9. COUNTY OF DEATH</b> Baltimore Md.					
<b>10. CITY OR TOWN OF DEATH</b> Towson			<b>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</b> St. Joseph's Hospital			<b>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</b> Homemaker			<b>12b. KIND OF BUSINESS OR INDUSTRY</b>		
<b>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</b> Maryland				<b>13b. COUNTY</b> Baltimore		<b>13c. CITY OR TOWN</b> Baltimore		<b>13d. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>13e. STREET AND NUMBER</b> 7410 Old Harford Road	
<b>14. FATHER'S NAME</b> First Middle Last James H. Lightner				<b>15. MOTHER'S MAIDEN NAME</b> First Middle Last Agnes E. Henshaw							
<b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> Yes, na, or unknown) No				<b>16b. SOCIAL SECURITY NO.</b> 215-03-8172D		<b>17. INFORMANT</b> Address Mr. Samuel Goldsborough, 1251 Winston Ave.					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART 1. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Perforated gastric ulcer</u> <u>531.1</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b> <u>5401</u>											
<b>19a. DATE OF OPERATION</b>			<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>			<b>20a. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			<b>21b. TIME OF INJURY</b> HOUR A.M. Month Day Year P.M. 19		<b>21c. HOW INJURY OCCURRED</b> (Enter nature of injury in Part 1 or Part 2, Item 18.)						
<b>21d. INJURY OCCURRED</b> White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			<b>21e. PLACE OF INJURY</b> (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			<b>21f. LOCATION</b> Street or R.F.D. No.		City or Town		County State	
<b>22a. I certify that (I) (this hospital) attended the deceased from</b> <u>12-17</u> , 19 <u>68</u> , <b>to</b> <u>12-20</u> , 19 <u>68</u> , <b>that</b> <input checked="" type="checkbox"/> <b>(we) last saw the deceased alive on</b> <u>12-20-68</u> , <b>and that in</b> <input checked="" type="checkbox"/> <b>(my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</b>											
<b>22b. SIGNATURE</b> <i>Samuel G. H. Lee, M.D.</i>						<b>DEGREE</b> <input type="checkbox"/> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22c. DATE SIGNED</b> 12-21-68			
<b>22d. PHYSICIAN'S NAME (Type)</b> Samuel G. H. Lee, M.D.						<b>22e. ADDRESS</b> 7620 York Rd. Towson 4, Md.					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE</b> 12/24/68.		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Parkwood Cemetery		<b>23d. LOCATION (City or Town)</b> Baltimore, Md.		(County) (State)			
<b>24. FUNERAL DIRECTOR</b> ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214						<b>25a. REG. BY REGISTRAR</b> DEC 23 1968		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles J. ...</i>			

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UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE



Attorney General

Department of Justice

Washington, D.C.

21-11-1958 (100-100000-100000)

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

17019

17059

1. DECEASED-NAME (Type or print) <b>Robert F Goodell</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>68</b>			2b. HOUR <b>11:35</b> M		
3. SEX <b>MALE</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>12/28/1986</b>		6. AGE (In years lost birthday) <b>81</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CHESAPEAKE MANOR NURSING HOME 329 E TOWSON</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>5648 Woodmont Ave</b>			13f. APT. NO. <b>APT A</b>					
14. FATHER'S NAME First Middle Last <b>Charles F. Goodell</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Ada Graham</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215 07 8869</b>		17. INFORMANT Address <b>Eleanor Goodell, 5648 Woodmont Ave. 21212</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from <b>may</b> , 19 <b>66</b> , to <b>DEC</b> , 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>12/24/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (and not) view the body after death.								
22b. SIGNATURE <b>W.M. Smith</b>				DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/27/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>W.M. Smith</b>				22e. ADDRESS <b>6305 THE ALAMEDA</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 28, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick, Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, Towson, MD. 21204</b>				25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

<div>17050</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17060</div>											
1. DECEASED-NAME (Type or print) First Middle Last Rosie B. Gover						2a. DATE OF DEATH Month Day Year December 19 1968			2b. HOUR 4:00 AM		
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH 2-21-1882			6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Frederick Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Reistertown Rd.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bent Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rural		
14. FATHER'S NAME First Middle Last William Ford				15. MOTHER'S MAIDEN NAME First Middle Last Loretta Belt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 217 189915		17. INFORMANT Address Walter F. Grover, 524 Fairview, Baltimore, 21224						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure - chronic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis - generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4409 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 weeks 7 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from September 18 1968, to December 19 1968, that (I) (we) lost the deceased alive on December 18 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. E. McWilliams MD						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) C. E. McWilliams						22c. DATE SIGNED 12-19-68					
22e. ADDRESS 11904 Reistertown Rd Reistertown Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-21-68		23c. NAME OF CEMETERY OR CREMATORY Fairview Methodist			23d. LOCATION (City or Town) (County) (State) Towson, Baltimore, Md. 21204				
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, MD.				ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles Young			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>COLEMAN. ROYERS GRAY.</b>			2a. DATE OF DEATH Month <b>DEC</b> Day <b>25</b> Year <b>68</b>			2b. HOUR M					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 15 1882</b>		6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY</b> Md.					
10. CITY OR TOWN OF DEATH <b>COCKEYSVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MARYLAND MASONIC HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>KENTUCKY</b>			13b. COUNTY <b>LOUISVILLE</b>		13c. CITY OR TOWN <b>LOUISVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1508 MORTON AVE</b>		
14. FATHER'S NAME First Middle Last <b>NORBORNE GAY GRAY.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ELLA GRAY.</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>090-09-1630</b>		17. INFORMANT <b>Md Masonic Home</b>		Address <b>Sec 2 10</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic Vas. Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4200</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>8 yrs.</b>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (the hospital) attended the deceased from <b>Dec 1</b> , 19 <b>68</b> , to <b>Dec 25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec 24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Carl F. Benson</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>Carl F. Benson</b>						22e. ADDRESS <b>5111 York Rd. Balt. Md 21212</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-27-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION (City or Town) <b>BALTIMORE</b>		(County)		(State) <b>Md</b>	
24. FUNERAL DIRECTOR <b>Wm Corp. Brooks Inc</b>				ADDRESS <b>1212 St Paul St Baltimore, Md</b>		25a. REC'D BY REGISTRAR <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

13071

EXPLANATION OF DEATH

13071

13071

13071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) Miss Jeannette Fitzgerald Green						2a. DATE OF DEATH Month Day Year Dec. 9 1968			2b. HOUR 40 P.M.				
3. SEX female		4. RACE white		5. DATE OF BIRTH Sept. 11, 1880			6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Freeland Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Md.							
10. CITY OR TOWN OF DEATH Cockeysville Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bonnie BLink (Masonic Home)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 502 Balto. Ave.			
14. FATHER'S NAME First Middle Last James Ellis Green						15. MOTHER'S MAIDEN NAME First Middle Last Margaret Lane							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No				16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs Dorothy L. Young RDB 2 Box 61 S. Branch Rd. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 4129													
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic Cardiovascular Disease 5 yrs													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4221													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1968, to Dec. 9, 1968, that (I) (we) last saw the deceased alive on Dec. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Carl F. Benson MD								DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Dec. 9, 1968			
22d. PHYSICIAN'S NAME (Type) Carl F. Benson MD								22e. ADDRESS 5111 York Rd Balto. Md 21112					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 12-12-68		23c. NAME OF CEMETERY OR CREMATORY GOUANS Presbyterian				23d. LOCATION (City or Town) (County) (State) GOUANS - MD.			
24. FUNERAL DIRECTOR Wm Cook Brooks Towson				ADDRESS 1050 York Rd Towson Md 21204				25a. REC'D BY REGISTRAR DATE DEC 12 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

17005

RECEIVED OF DEPT

17005

DEC 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17053

CERTIFICATE OF DEATH

17063

1. DECEASED-NAME (Type or print) First Middle Last <b>JOHN RAYMOND GRITZ</b>			2a. DATE OF DEATH 12 Month 28 Day 68 Year		2b. HOUR 7:30 a.m.
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>March 7, 1902. 1901</b>		6. AGE (In years lost birthday) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE Co.</b> Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CEN.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Fireman</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>3337 Woodside Avenue</b>	
14. FATHER'S NAME First Middle Last <b>Antony Gritz</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Lena Deitz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-24-4049A</b>	17. INFORMANT Address <b>Mrs. Margaret M. Gritz (Same)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTASTIC CARCINOMA of LUNG</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>163X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (A) (this hospital) attended the deceased from <b>12-5</b> , 1968, to <b>12-28</b> , 1968, that (B) (we) lost saw the deceased alive on <b>December 28, 1968</b> , and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above, (D) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Eduardo M. Canilang M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>12/28/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. EDUARDO M. CANILANG M.D.</b>		22e. ADDRESS <b>6701 N. Charles St. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/31/68.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Luck, Inc. Balto. Md. 21211</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STATE OF NEW YORK

IN SENATE

January 1, 1900

REPORT OF THE

COMMISSIONER

OF THE LAND OFFICE

FOR THE YEAR 1899

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ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1900.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 14. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17051

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17064

1. DECEASED-NAME (Type or Print) <b>CHARLES R. GROSS</b>			2a. DATE KNOWN OF DEATH Month <b>DEC</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>10 A.M.</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>MAY 20 1896</b>	6. AGE (In years last birthday) <b>72 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>DEC</b> Day <b>20</b> Year <b>1968</b>	2d. HOUR <b>11 A.M.</b>
7a. BIRTHPLACE (State or foreign country) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>			Md.
10. CITY OR TOWN OF DEATH <b>ESSEX</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2224 MONOCACY RD</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY <b>R.R.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2224 MONOCACY RD</b>	
14. FATHER'S NAME First <b>DAVID</b> Middle <b>GROSS</b> Last <b>GROSS</b>			15. MOTHER'S MAIDEN NAME First <b>ANNA</b> Middle <b>WALDEMEYER</b> Last <b>WALDEMEYER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>			
16b. SOCIAL SECURITY NO.			17. INFORMANT <b>MAUDE GROSS</b>			ADDRESS <b>ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221 Diabetes Mellitus</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>MELVIN B. DAVIS M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>12-21-68</b>
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>6800 HORNINGTON RD BUNDALE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>12/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>QUICKELS</b>		23d. LOCATION (City or Town) <b>MANCHESTER</b>		(County) <b>PA</b>	(State)
24. FUNERAL DIRECTOR <b>J. G. CONNELLY SONS</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

15068

MEDICAL EXAMINER'S REPORT OF DEATH

FILE NO.  
HEALTH DEPT.

15068 J 15068

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17055

Item 10 Film G408 1/23/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17065

1. DECEASED-NAME (Type or print) First Middle Last <b>RICHARD GRUBE</b>			2a. DATE OF DEATH Month Day Year <b>12/28/68</b>			2b. HOUR <b>9:45 a.m.</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>8/16.1897</b>		6. AGE (In years lost birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3001 Woodside Ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>contractor</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3001 Woodside Ave.</b> <b>21234</b>	
14. FATHER'S NAME First Middle Last <b>Ernest Grube</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Wilhelminia Magel</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b. SOCIAL SECURITY NO. <b>213 05 7362</b>		17. INFORMANT <b>family records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF <b>PREVIOUS CEREBRAL THROMBOSIS</b> (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>2 1/2 YRS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>332 X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/3</b> , 19 <b>62</b> , to <b>12/28</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>12/28</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Leonard Paul Berger</b>		22c. DATE SIGNED <b>12/28/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Leonard Paul Berger</b>				22e. ADDRESS <b>8100 Harford Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/31/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>C. F. EVANS &amp; SON, 8802 Harford Rd.</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

17056

17066

1. DECEASED-NAME (Type or print) <b>WALTER THOMAS GUERKE</b>			2a. DATE OF DEATH 12 Month 27 Day 68 Year			2b. HOUR <b>9:55</b> AM			
3. SEX <b>M.</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 29, 1888</b>		6. AGE (In years lost birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>GREATER BALTO. MED. CEN</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Paint</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>6818 Blenheim Rd.</b>	
14. FATHER'S NAME First Middle Lost <b>Charles Guerke</b>			15. MOTHER'S MAIDEN NAME First Middle Lost <b>Mary Long</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-18-5139 A</b>		17. INFORMANT <b>Mrs. Myrtle D. Guerke</b>		Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>492X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>SPONTANEOUS PNEUMOTHORAX</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC EMPHYSEMA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5271 RESPIRATION PNEUMONIA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/26/68</b> , 19 <b>68</b> , to <b>12/27, 1968</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E. Larranaga</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/27/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>E. LARRANAGA, MD.</b>				22e. ADDRESS <b>6701 N. CHARLES ST. BALTO. MD 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>12/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto Md</b>			
24. FUNERAL DIRECTOR <b>Mitchell-Woodfield Home 6500 York Rd</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print) <b>SALVATORE</b>						First <b>GUGLIUZZA</b>			Last <b>A</b>			2a. DATE OF DEATH Month <b>DEC</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>11</b> M <b>P</b>	
3. SEX <b>MALE</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>30 Oct 1881</b>			6. AGE (In years last birthday) <b>87</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>ITALY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.							
10. CITY OR TOWN OF DEATH <b>BALTO-RURAL</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7519 Belair Road.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTO.</b>			13c. CITY OR TOWN <b>BALTO-RURAL</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>7519 Belair Rd 21236</b>				
14. FATHER'S NAME First <b>VINCENZO</b> Middle <b>GUGLIUZZA</b> Last <b>A</b>			15. MOTHER'S MAIDEN NAME First <b>ROSARIA</b> Middle <b>A</b> Last <b>A</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>215-12-9655</b>			17. INFORMANT Address <b>4102 Glenmore Balto 21202</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic sclerotic Cardiovascular Disease Unst</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4221</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) _____																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <b>6 Dec, 1968</b> , to <b>12 Dec, 1968</b> , that (I) (we) lost the deceased alive on <b>6 Dec, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>John C. Hyle MD</b>			DEGREE <b>MD</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>13 Dec 68</b>							
22d. PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>			22e. ADDRESS <b>7527 Belair Rd 21236</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>DEC 16 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Maryland.</b>							
24. FUNERAL DIRECTOR <b>D. P. Pei Bros Inc.</b>			ADDRESS <b>7110 Belair Road.</b>			25a. REC'D BY REGISTRAR <b>21206</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							
						DATE <b>DEC 16 1968</b>										

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div>17058</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17068</div>												
1. DECEASED-NAME (Type or print) First Middle Last <i>Naomi L. Haas</i>						2a. DATE OF DEATH Month Day Year <i>12 7 68</i>			2b. HOUR <i>12N</i>			
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>9-9-1887</i>			6. AGE (In years last birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltico.</i>			Md.			
10. CITY OR TOWN OF DEATH <i>Garrison</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Fox Leigh N.H.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>BALTO. MD</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>211 Cedarcroft Rd.</i>			
14. FATHER'S NAME First Middle Last <i>THOMAS LAMBDIN</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>BARRINGER</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or unknown (If yes give war or dates of service) <i>No</i>				16b. SOCIAL SECURITY NO. <i>215-10-54948</i>		17. INFORMANT Address <i>Bessie M. S. Verwood - 211 Cedarcroft Rd.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4129</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis and aortic disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>10-30</i> , 19 <i>68</i> , to <i>12-7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-6</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Vicki M. Jenkins MD</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <i>12-7-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>VICKI M. JENKINS MD</i>								22e. ADDRESS <i>Spring Grove State Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/10/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>						
24. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co.</i> ADDRESS <i>1905 York Rd. Balto. 12, Md.</i>						25a. REC'D BY REGISTRAR <i>DEC 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				

15008

RECORD OF WORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 2 See birth cert. <sup>ams</sup> MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
17059					CERTIFICATE OF DEATH					17069				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville 1433 Taylor Ave.</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8814 Baker Avenue, Balto., Md. 21234</b>					d. STREET ADDRESS <b>8814 Baker Avenue, Balto., Md. 21234</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Haberstich</b> Last					4. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>19 68</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-28-68</b>		9. AGE (In years last birthday) — yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>August Haberstich</b>						14. MOTHER'S MAIDEN NAME <b>Patricia Pirtle</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family Records</b> Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>778.2</b> IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhage</b> DUE TO last. (c)										INTERVAL BETWEEN ONSET AND DEATH <b>40 min.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>7715</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>12-28</b> , 19 <b>68</b> , to <b>12-28</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) lost the deceased alive on <b>12-28-68</b> , 19 <b>68</b> , and that death occurred at <b>11:30am</b> , from causes and on the date stated above.														
22a. SIGNATURE <i>Coral Gordon</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.				22b. DATE SIGNED <b>12-30-68</b>				
22c. PHYSICIAN'S NAME (Type) <b>Coral Gordon, M.D.</b>						22d. ADDRESS <b>611 Park Avenue, Balto., Md. 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hoy Redeemer Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>						
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

UNITED STATES DEPARTMENT OF JUSTICE  
DIVISION OF INVESTIGATION

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REPORT OF CASE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1707 Roland Avenue</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> d. STREET ADDRESS <u>1707 Roland Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Joseph</u> Middle <u>Gratt</u> Last <u>Hales</u>			<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>20</u> Year <u>1968</u>			<b>5. SEX</b> <u>Male</u>			<b>6. COLOR OR RACE</b> <u>White</u>							
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>August 6, 1893</u>			<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.														
Months	Days	Hours	Min.													
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bendix Radio Corp.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>								
<b>13. FATHER'S NAME</b> <u>Robert Hales</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie Pickett Fricker</u>										
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW I</u>			<b>16. SOCIAL SECURITY NO.</b> <u>215-22-7720</u>			<b>17. INFORMANT</b> <u>Mae E. Hales, Roland Ave., Ruxton, Md.</u>			<b>Address</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liner</u> 197.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 mo</u>						
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>1581</u>																
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)												
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)								
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 13, 1956</u> <b>to</b> <u>Dec 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 16, 1968</u> and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.																
<b>22a. SIGNATURE</b> <u>George T. Gilman</u> (M.D.)						<b>22b. DATE SIGNED</b> <u>12/20/68</u>		<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b>						
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>Dec. 23, 1968</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Dulaney Valley Memorial</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>Cockeysville, Md.</u>								
<b>24. FUNERAL DIRECTOR</b> <u>John Burns' Sons, Towson, Maryland</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DEC 23 1968</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles J. [Signature]</u>								

17010

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Address

Version

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17061										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17071									
Item 13 Film 407 12/23/68 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR M														
Bertha					L. Hall					December 6, 1968																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
Female			Caucasian			Jan. 23, 1889			79 YRS.																				
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
New York					U.S.A.										BALTIMORE Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Towson					Armcast Nursing Home					Federal Govt.																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Md.					Baltimore					Baltimore					YES <input type="checkbox"/> NO <input type="checkbox"/>					3129N. Calvert St. 8491 Register Ave									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Vernon L. Hall					Mary I. Benson																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
No					218-22-0146					Adelaide Johnson, 102 W. 39th St. 21210																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>																													
4369 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
(b) <i>Cerebral arteriosclerosis</i>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
331X <i>Parkinson's Disease</i>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from April, 1967, to Dec 6, 1968, that (I) (we) last saw the deceased alive on Dec 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>Fannklin E. Leslie MD</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12/8/68																			
22d. PHYSICIAN'S NAME (Type) Fannklin E. Leslie M. D.										22e. ADDRESS Marylander Apartments # 142																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12-9-1968					Loudon Park Cemetery					Baltimore, Maryland														
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE														
Wm. Cook-Brooks Inc. 1217 St. Paul St., Balto., Md. 21202										DEC 12 1968					<i>J. Charles Judge</i>														

1702

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1702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>17062</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>17072</span> </div>																									
1. DECEASED-NAME (Type or print)			First Joan			Middle Ora			Last HANDSCHUH			2a. DATE OF DEATH Month 12			Day 4			Year 68			2b. HOUR 3:35 A M				
3. SEX Female			4. RACE White			5. DATE OF BIRTH 7/25/32			6. AGE (In years lost birthday) 36 YRS.			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			HOURS			MIN.				
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.																
1d. CITY OR TOWN OF DEATH Owings Mills			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dependent			12b. KIND OF BUSINESS OR INDUSTRY none																
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY -			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 128 West Burnett Street													
14. FATHER'S NAME First Adam			Middle -			Last Handschuh			15. MOTHER'S MAIDEN NAME First Naomi			Middle -			Last Wilson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			(If yes give war or dates of service) ---			16b. SOCIAL SECURITY NO. none			17. INFORMANT Address Rosewood Records, Owings Mills, Maryland																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>345.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epilepsy</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>353.3</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that <del>(X)</del> (this hospital) attended the deceased from <u>10/18</u> , 19 <u>39</u> , to <u>12/4</u> , 19 <u>68</u> , that <del>(X)</del> (we) last saw the deceased alive on <u>12/4</u> , 19 <u>68</u> , and that in <del>(our)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I)</del> (we) (did) (did not) view the body after death.																		22b. SIGNATURE <u>Nevzat Turkman</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/4/68			
22d. PHYSICIAN'S NAME (Type) Nevzat Turkman, M.D.			22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.																						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/7/68			23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.																
24. FUNERAL DIRECTOR <u>McCully F.H.</u>			ADDRESS 237 Patapsco Ave. 21225			25a. REC'D BY REGISTRAR DATE DEC 9 1968			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>																

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17063

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 07 12/16/68 kk

CERTIFICATE OF DEATH

17073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Reside before admission) a. STATE <b>Maryland</b> <b>b. COUNTY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>				d. STREET ADDRESS <b>3501 Oakmont Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Eudora</b> Last <b>Hanley</b>				4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1968</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1891</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph W. Boothe</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Agnes Keller, Crain Courts, P.O. Box 664 21061</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4409 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4500</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-25</b> , 19 <b>68</b> , to <b>12-3</b> , 19 <b>68</b> , that I last saw the deceased alive on <b>12-3</b> , 19 <b>68</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3915 HOLLINS FERRY RD</b> DATE SIGNED <b>12/3/68</b>							
ACTUAL SIGNATURE <b>Domingo</b>		M.D. <b>DOMINGO C. SORDONGON, M.D. BALTIMORE Md. 21227</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-6-1968</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore City, Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

279

11

Generalizing Interview  
Comparative Heart Failure

0-51-274-000

DOMINGO C. RODRIGUEZ M.D. BALTIMORE MD 21243  
3012 MOLLIN FERRY RD 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10-68)  
304 REV. 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>17064</span> <span>CERTIFICATE OF DEATH</span> <span>17074</span> </div>									
1. DECEASED-NAME (Type or print) First Middle Last KATHERINE ELIZABETH HANSEN					2a. DATE OF DEATH Month Day Year Dec 24 68		2b. HOUR 9:20 P		
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH 4-13-84		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) BALTO, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO Md.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO COUNTY GEN. Hos.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3610 Buckingham Rd	
14. FATHER'S NAME First Middle Last HENRY KAISER					15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Yenlner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Harry J. Hansen, 3610 Buckingham Rd. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hours
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-23, 1968, to 2-24, 1968, that (I) (we) last saw the deceased alive on 2-24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gregorio Marfori MD DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-24-68		
22d. PHYSICIAN'S NAME (Type) Gregorio Marfori					22e. ADDRESS Baltimore County General Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-28-68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City, Baltimore Md.			
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229					25a. REC'D BY REGISTRAR DATE DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

27072

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>17085</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17075</div>											
1. DECEASED-NAME (Type or print) <b>George A. Harbaugh</b>				First Middle Last		2a. DATE OF DEATH <b>12-25-1968</b>		Day Year		2b. HOUR <b>6 P.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>11-12-1891</b>			6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>					
10. CITY OR TOWN OF DEATH <b>Towson, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto; Medical Center</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Watchmaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lutherville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>818 Kellogg Road</b>			
14. FATHER'S NAME <b>James H. Harbaugh</b>				First Middle Last		15. MOTHER'S MAIDEN NAME <b>Mary Elizabeth ?</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>212-05-7773</b>		17. INFORMANT <b>Hazel M. Jester</b> Address <b>818 Kellogg Road</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> , 1962, to <b>DEC</b> , 1968, that (I) (we) last saw the deceased alive on <b>12/25</b> , 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. M. Smith</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/27/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>W. M. Smith</b>		22e. ADDRESS <b>6305 THE ALAMEDA</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-30-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hereford Baptist Church</b>			23d. LOCATION (City or Town) (County) (State) <b>Hereford, Maryland</b>				
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>				ADDRESS <b>1050 York Rd. 21204</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

I

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Manner of death: [illegible]

6. Name of physician: [illegible]

7. Name of funeral home: [illegible]

8. Name of next of kin: [illegible]

9. Name of informant: [illegible]

10. Date of report: [illegible]

11. Signature of informant: [illegible]

12. Signature of physician: [illegible]

13. Signature of funeral home: [illegible]

14. Signature of next of kin: [illegible]

15. Signature of informant: [illegible]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 11 Film 68  
1/3/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17076

1. DECEASED-NAME (Type or Print) First Middle Last <b>ROBERT B. HARRIS</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>12 18 1968</b>			2b. HOUR 11:45			
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>Aug. 11, 1916</b>	6. AGE (In years last birthday) <b>52 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>December 18, 1968</b>	2d. HOUR 11:15a
7a. BIRTHPLACE (State or foreign) <b>Lincolnton, N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>			12b. KIND OF BUSINESS OR INDUSTRY Md.
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>100 Dumbarton Rd. 3710 Forrest Park Ave.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>3710 Forrest Park Ave.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3710 Forrest Park Ave.</b>
14. FATHER'S NAME First Middle Last <b>Irred Harris</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Nannie Edwards</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>23-01-5369</b>		17. INFORMANT <b>Mrs. Maria Harris</b>			ADDRESS <b>3710 Forrest Park Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221									
19a. DATE OF OPERATION <b>Dec. 23, 1968</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Edward F. Wilson</b>			M.D. <b>Edward F. Wilson, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12/18/68</b>	
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>5501 Induckin Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Joseph L. Rues</b>				ADDRESS <b>2222 W. Mount Carmel</b>		25a. CITY OF REGISTRATION <b>Baltimore</b>		25b. REGISTRAR <b>James J. Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
JOHN THORNTON HARRISON						DECEMBER 19, 1968		7:10p M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		NEGRO		2/7/1900		68				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
VIRGINIA		U.S.A.				BALTIMORE Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VETERANS ADMIN. HOSPITAL			JANITOR				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ANNE ARUNDEL		GLEN BURNIE		YES		9 SCOTT AVENUE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
JOHN - - HARRISON			MANDY - -							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES WWII			213 10 91 57		CLINICAL RECORDS, VAH, FT. HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1550 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1550 (b) HEPATOMA WITH METASTASES TO REGIONAL LYMPH NODES AND BLADDER DUE TO, OR AS A CONSEQUENCE OF (c) PORTAL CIRRHOSIS LIVER									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN OLD	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) BILE NEPHROSIS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <del>xx</del> (this hospital) attended the deceased from NOV. 11, 1968, to DEC. 19, 1968, that <del>xx</del> (we) last saw the deceased alive on DEC. 19, 1968, and that in <del>xx</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>xx</del> (we) (did) <del>xxxx</del> view the body after death.										
22b. SIGNATURE <i>Peter W. Juvan</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 12/20/68				
22d. PHYSICIAN'S NAME (Type) PETER W. JUVAN, M. D.						22e. ADDRESS VAH, FT. HOWARD, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		12/24/68		BALTIMORE NATIONAL		BALTIMORE, MD.				
24. FUNERAL DIRECTOR 1. Carroll,				ADDRESS HALSTEAD FUNERAL HOME		25a. REC'D BY REGISTRAR 12/23/68		REGISTERED SIGNATURE <i>[Signature]</i>		
				W. NORTH AVE. BALTIMORE, MD.						

11077

DECEMBER 19, 1952 1:10P

ALABAMA  
U.S.A.  
BIRMINGHAM

DR. HOWARD  
VETERINARY ADMIN. HOSPITAL  
X  
2 BOOTH AVENUE

JOHN  
BIRMINGHAM  
X  
X

WILL  
100 TO 21 ST. CLINICAL HOSPITAL, VAN, ET. HOWARD, MD.

ALABAMA  
U.S.A.  
BIRMINGHAM

NOV. 11, 1952

X  
VAN, ET. HOWARD, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17068

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17078

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Town)</u>		d. STREET ADDRESS <u>100 Allegany Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES W HARRON</u>		4. DATE OF DEATH <u>Dec 26 1968</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/1926</u>
9. AGE (In years lost birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dentist -retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alec D. Harrower</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Pendleton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-2899</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>485X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>491X</u> <u>Arteriosclerotic Organic Brain Disease, Fracture of Hip.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Presented while walking at Spring Grove St Hospital</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>Dec 13 1968</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. Nelson McKay</u> M.D.		22. DATE SIGNED <u>Dec 26, 1968</u>	
EXAMINER'S NAME (Type) <u>J. Nelson McKay</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 28, 1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Towson, Md.</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 31 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17069

17079

1. DECEASED-NAME (Type or Print) <b>JOHN THEODORE HART</b>		20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>DEC 3 19 68</b>		2b. HOUR <b>11 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>6/26/1887</b>	6. AGE (In years last birthday) <b>81 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b>
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>George</b> Middle <b>Hart</b> Last <b>Hart</b>		15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Fleckenstein</b> Last <b>Fleckenstein</b>		13e. STREET AND NUMBER <b>2904 Park Terrace</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Elizabeth Williams, 2904 Park Terrace</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>887X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RIGHT PARIETAL SKULL FRACTURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9040</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>7 12/3 19 68</b> HOUR A.M. <b>7</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>FELL AT HOME</b>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>HOME</b>		21f. LOCATION Street or R.F.D. No. <b>2904 PARK TERR.</b> City or Town <b>PARKVIEW</b> County <b>BALTO.</b> State <b>MD.</b>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>William A. Piusbury</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12/4/68</b>
EXAMINER'S NAME (Type) <b>William A. Piusbury</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <b>Baltimore, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home 4210 Belair Road.</b>		23d. LOCATION (City or Town) <b>Baltimore, Md.</b> (County) (State)		25a. REC'D BY REGISTRAR <b>DEC 11 1968</b>
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

17073

RECORD OF INVESTIGATION

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DEC 1 1968

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

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17070

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17080

1. DECEASED-NAME (Type or Print) <b>JOHN Adolph Hartman</b>				2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input checked="" type="checkbox"/> Year <b>1968</b>				2b. HOUR <b>10 AM</b>	
3. SEX <b>MAL</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>12 Sept 1903</b>	6. AGE (In years last birthday) <b>65 YRS.</b>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD <b>Dec 30</b> Year <b>1968</b>			2d. HOUR <b>10 AM</b>
7a. BIRTHPLACE (State or foreign country) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>			
10. CITY OR TOWN OF DEATH <b>White Marsh Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Box 892, Carrington Dr. White Marsh, Md.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Inspector</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: admission) STATE <b>Md</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>White Marsh</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>3x892 Carrington Dr</b>	
14. FATHER'S NAME <b>John Hartman</b>			15. MOTHER'S MAIDEN NAME <b>Regina Gebanne Schobel</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>213 075894</b>		17. INFORMANT <b>Geo. Loren Hartman</b>			ADDRESS <b>2726 Moorgate Rd</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUT and Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John C. Hyle</b>		EXAMINER'S NAME (Type) <b>JOHN C. Hyle M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county) <b>7557 Bala Rd Balto</b>		22b. DATE SIGNED <b>12-30-68</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/2/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) <b>Balto., Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home</b>				25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			
ADDRESS <b>3331 Brehms Lane 21213</b>									

11030

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

TO THE SECRETARY, U. S. DEPARTMENT OF AGRICULTURE  
FROM THE SECRETARY, U. S. DEPARTMENT OF AGRICULTURE  
SUBJECT: [Illegible]

[The body of the letter contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a formal communication, possibly a memorandum or a letter, discussing agricultural matters.]

Very respectfully,  
[Illegible Signature]

1 MAY 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>ROLAND ZACHARIAH HARVEY</b>						2a. DATE OF DEATH <b>12</b> Month <b>11</b> Day <b>1968</b> Year			2b. HOUR <b>7:05 A M</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>2/27/1902</b>			6. AGE (In years lost birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County, Md.</b>						
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1512 Boylston Street</b>		
14. FATHER'S NAME First <b>Zachariah</b> Middle <b>Harvey</b> Last <b>Collins</b>				15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Last <b>Collins</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>212-12-4298</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>										<b>2 mos.</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b>										<b>1 yrs</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Glaucoma, b. lateral</b>										<b>12 yrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4200 Pulmonary Tuberculosis (minimal) with Rt. pleural effusion</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>9/27/1968</b> , to <b>12/11/1968</b> , that (I) (we) last saw the deceased alive on <b>12/11/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>W. Newcomer</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/11/68.</b>				
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>						22e. ADDRESS <b>Mount Wilson, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-14-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) <b>Barto, Md.</b> (County) (State)					
24. FUNERAL DIRECTOR <b>John H. Hahn Funeral Home, 4200 Pennington Ave.</b>						25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

Alameda County

County of Alameda

In accordance with the provisions of the

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17072

17082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>JOSEPH E. HASKELL</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>8:55AM</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>11/23/1880</b>		6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MD.-U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County, Md.</b>				
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Capt. Fire Department</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>935 Astwood Rd.</b>	
14. FATHER'S NAME First Middle Last <b>George Haskell</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Hamilton</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>218-26-0372</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis (probable).</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>4207</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Chronic Bronchitis - Pulmonary Emphysema</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>11/22/1968</b> , to <b>12/19/1968</b> , that (I) (we) last saw the deceased alive on <b>12/19/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W. Newcomer</b>						22c. DATE SIGNED <b>12/19/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>						22e. ADDRESS <b>Mount Wilson, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave. 21229</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>				

California County

San Diego County

San Diego County

San Diego County

San Diego County

San Diego County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Marie</i>			First <i>E</i> Middle <i>Hatten</i> Last			2a. DATE OF DEATH Month <i>Dec</i> Day <i>14</i> Year <i>68</i>			2b. HOUR <i>7:15 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>3/27/87</i>			6. AGE (In years lost birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County</i> Md.				
10. CITY OR TOWN OF DEATH <i>Randallstown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Balto Co Gen H</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>At Home</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>21207</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>4120 Villa Nova Rd.</i>	
14. FATHER'S NAME First <i>Frederick</i> Middle <i>Miller</i> Last			15. MOTHER'S MAIDEN NAME First <i>William H. Hood</i> Middle <i>4120 Villa Nova Rd.</i> Last <i>21207</i>			17. INFORMANT <del>XXXXXXXXXXXXXXXXXXXX</del>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>XXXXXXXXXXXX</i>			17. INFORMANT <del>XXXXXXXXXXXXXXXXXXXX</del>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>AORTIC ANEURYSM</i> <i>4120</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>HCU D</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>443 X</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes.</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>B. Vanasin</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <i>Boon VANASIN</i>						22e. ADDRESS <i>Balto County Gen. Hosp.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-18-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Nisky Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Bethlehem Pennsylvania</i>				
24. FUNERAL DIRECTOR <i>Ellsworth Armacost-4600 Liberty Hghts. Ave</i>						25a. REC'D BY REGISTRAR <i>DEC 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/68

MEDICAL CERTIFICATION

17074				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17084									
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR			
GEORGE								HAUSNER		12 Month 10 Day 68 Year		7:50 AM					
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost, birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
MALE		WHITE		5/20/95				73 YRS.									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.					
MARYLAND		U.S.A.				BALTIMORE COUNTY,											
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
FORT HOWARD		VET. ADM. HOSPITAL, FT HOWARD, MD.						ENGINEER		U.S. GOVERNMENT							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
MARYLAND				BALTIMORE				408 S. CLINTON STREET									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
ALOIS						HAUSNER		JOHANNA						BIHLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES		(If yes give war or dates of service) WW-1		16b. SOCIAL SECURITY NO.		17. INFORMANT Address											
				213 10 3535		CLIN. REC., VAH, FT. HOWARD, MARYLAND											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNANCY OF GASTROINTESTINAL TRACT WITH</u> <u>159X</u> <u>DUE TO, OR AS A CONSEQUENCE OF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>ASCITES AND METASTASIS TO OMENTUM</u> <u>DUE TO, OR AS A CONSEQUENCE OF</u> (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>159X</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that (X) (this hospital) attended the deceased from <u>9/9/68</u> , 19 <u>68</u> , to <u>12/10/68</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>12/10/68</u> , 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Sung Ill Shin</u>												DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/10/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>SUNG ILL SHIN, M.D.</u>												22e. ADDRESS <u>VAH FORT HOWARD, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
BURIAL		12/13/68		MORELAND MEMORIAL CEMETERY				BALTIMORE MARYLAND									
24. FUNERAL DIRECTOR				Schimunek Funeral Home ADDRESS 3331 Brehms Lane, Balto. Md.				25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

17084

RECEIVED

17084

RECEIVED



17084

17075

## CERTIFICATE OF DEATH

## 1. NAME OF DECEASED

Type or Print

Mary K. Hearney

## 2. DATE AND HOUR OF DEATH

Dec. 22, 1968

M.

## 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BALTIMORE COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

413 Academy Rd. Catonsville, Md.

## 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

## C. CITY OR TOWN

## D. INSIDE CITY LIMITS?

Catonsville

YES ☐NO ☒

## E. STREET AND NUMBER

413 Academy Road

## 5. SEX

Female

## 6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

## 8. DATE OF BIRTH

9-20-1895

9. AGE (In years  
lost birthday)

73

## If Under 1 Yr.

Months

Days

## If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most at working life, even if retired)

Housewife

## 10B. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

New Jersey

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Patrick Sullivan

## 14. MOTHER'S MAIDEN NAME

Mary

## 15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

## 17. INFORMANT

## ADDRESS

Mrs. Mary R. Wilhide, 413 Academy Road 21228

## 18.

I 4120  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last. 4422

## CAUSE OF DEATH

## (A) IMMEDIATE CAUSE

Myocardial failure  
DUE TO, OR AS A CONSEQUENCE OF:

## (B)

Hypertensive-arteriosclerotic CVD  
DUE TO, OR AS A CONSEQUENCE OF:

## (C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 days

10 years

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL

22. I certify that (I) (this hospital) attended the deceased from March 1968 to Dec. 22 1968

that (I) (we) lost saw the deceased alive on Dec. 21 1968 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

## 23A. SIGNATURE

Kennard Yaffe MD

DEGREE

Attending  
Phys.☒Med.  
Director☐Staff  
Phys.☐

## 23B. DATE SIGNED

12/22/68

23C. PHYSICIAN'S  
NAME (Type)

Kennard

Yaffe

DEGREE

## 23D. ADDRESS

5501 Forest Park Ave Back Md 21207

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 24B. DATE

12-24-68

## 24C. NAME of CEMETERY or CREMATORY

Calvary Cemetery

## 24D. LOCATION

(City, town, or county)

(State)

Newburgh, New York

## 25A. DATE REC'D BY HEALTH DEPT.

DEC 23 1968

## 25B. NAME OF REGISTRAR

Charles Judge

## 25C. FUNERAL DIRECTOR

## ADDRESS

Howard H. Hubbard Funeral Home  
4107 Wilkens Ave. Baltimore Md. 21229TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in no event within 72 hours after death.

VR AL  
45M -



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 5 Film G407 12/5/68 kk										MARYLAND STATE DEPARTMENT OF HEALTH														
17076										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
1										17086														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR									
Lillian					Elizabeth					Heim					December 1 68 7:00 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Female			White			12-9-1887 1886			81 YRS.			MONTHS DAYS HOURS MIN.												
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
Maryland			U.S.A.						Baltimore Md.															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY															
Towson			St. Joseph Hospital			Housewife			At Home															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER												
Maryland			Baltimore			Parkville						3044 Edgewood Ave., -21234												
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																			
Frederick M. Lhen					Bertha - - -																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
No										Luther Heim					Same									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) cerebral hemorrhage																								
4319 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																								
(b) arterio sclerosis																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
331x																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 11/19/ 1968, to 12/1/ 1968, that (I) (we) last saw the deceased alive on 12/1/ 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
Jannie M. Langelan MD															12-1-68									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
															7620 York Rd., Towson Md. 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					12-4-68					Loudon Park					Baltimore Md									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Chas. F. EVANSTON															DATE DEC 3 1968					Charles Judge				

1-500

RECORDS OF DEATH

11080

TO THE  
TO THE  
TO THE

17077

CERTIFICATE OF DEATH

17087

1. DECEASED-NAME (Type or print) <i>Helen</i>		First <i>A.</i>		Middle <i>Hemming</i>		Last		2a. DATE OF DEATH Month <i>12</i> / Day <i>13</i> / Year <i>68</i>			2b. HOUR <i>2:45</i> P.M.	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>5/28/02</i>			6. AGE (In years lost birthday) <i>66</i> YRS.			IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.						
10. CITY OR TOWN OF DEATH <i>Catoxville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit M.H.M.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Bookkeeping</i>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Huntingdon</i>		13c. CITY OR TOWN <i>Huntingdon</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>700 Substing Place</i>				
14. FATHER'S NAME <i>Joseph P. Grochmal</i>		First <i>P.</i>		Middle <i>Grochmal</i>		Last		15. MOTHER'S MAIDEN NAME <i>Ofisher</i>		First <i>Ofisher</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>CALVIN GROCHMAL</i>		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic malignancy</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF from Breast (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>170X</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>August 1968</i> to <i>Dec 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>11/28/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.												
22b. SIGNATURE <i>R. P. Williamson</i>		22c. DATE SIGNED <i>12-13-68</i>		22d. PHYSICIAN'S NAME (Type) <i>5550 BALTIMORE</i>		22e. ADDRESS <i>BALTIMORE 28, MARYLAND</i>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>12/16/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WESTERN</i>		23d. LOCATION (City or Town) <i>BALTO. MD.</i>		County		State		
24. FUNERAL DIRECTOR <i>E-S. MACNABB</i>		24b. ADDRESS <i>21228</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17078										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17088				
Items #7a,b, & 8 Film G407 12/9/68										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
John Edward Hennegan										12 Month 3 Day 68 Year					8:15 a M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Male			White			12/28/05			62 YRS.			MONTHS DAYS HOURS MIN.												
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
Maryland			USA						Baltimore Md.															
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Towson					Greater Balto. Med. Center																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Md.					Baltimore					Lutherville					12 Nightengale Way									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																			
Henry Hennegan					Anna ?																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
No.					217 32 7521					Dorothy L. Hennegan, Lutherville, Md.														
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Abdominal carcinomatosis and																								
1530 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																								
(b) Intestinal obstruction																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c) Carcinoma of cecum																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
1530																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 10/19, 19 68, to 12/3, 19 68, that (I) (we) last saw the deceased alive on 12/3, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 12/3/68									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS														
Rudiger Breiteneker, M.D.										6701 N. Charles Street														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					Dec. 6, 68					Loudon					Baltimore, Baltimore, Md.									
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE									
Wm. Cook-Brooks T wson, T wson, Md. 21204										DEC 4 1968					f Charles Judge									

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TO THE

U.S. DEPT. OF THE INTERIOR

12/19/68 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19079

## CERTIFICATE OF DEATH

17689

1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR	
Frank		F.		Hertsch				12		11		68				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. AGE (In years last birthday)		8. MONTHS		9. DAYS		10. HOURS		11. MIN.	
Male		White		May 7, 1895		73											
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH											
Richmond Va.		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore,										Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last 12 months)		12b. KIND OF BUSINESS OR INDUSTRY											
Woodlawn Maryland		2021 Englewood Ave.		Retired Electrician		self emp											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Maryland		Baltimore		Woodlawn		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2021 Englewood Ave.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Unknown								Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address											
NO		218-14-8006		Frank F. Hertsch Jr.		2021 Englewood Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
401X		Cardiac Failure															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Hypertension													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		443X															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from Mar 15, 1963, to Dec 11, 1968 that (I) (we) last saw the deceased alive on Dec 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
George E. Shannon M.D.		Dec. 12, 1968		Dr. George Shannon		Medicial Arts Bulding											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)											
Burial		Dec. 14, 68		Woodlawn Cemetery		Woodlawn Balto. Co. Md.											
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Loring Byers		8728 Liberty Rd.		DATE DEC 16 1968		Charles Judge											

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

**Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 7 & 8 Film G 408  
12/31/68 kk

Item 13e Film G 408  
12/31/68 llw

17020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last <b>CHARLES HESS</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Dec. 15, 1968 <input type="checkbox"/> Dec. 15, 1968			2b. HOUR 9:00 P. M.		
3. SEX male	4. RACE white	5. DATE OF BIRTH	6. AGE (in years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD Month Day Year December 15, 1968		2d. HOUR 9:00 P. M.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cntr.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt 1 Box 6 4101 Granite Avenue Jemifer
14. FATHER'S NAME First Middle Last ?			15. MOTHER'S MAIDEN NAME First Middle Last ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-32-3401		17. INFORMANT ADDRESS Robert Wilson, 4101 Granite Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound of Head</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 955X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 776X								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 8:30 P.M. 12/15/9 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) subj. shot self in head				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. City or Town County State Baltimore Co., Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 12/16/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 12/18/68		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.				25. RECEIVED BY REGISTRAR DEC 20 1968 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>17081</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>17091</span> </div>											
1. DECEASED-NAME (Type or print) Charles R. Hildenbrand						2a. DATE OF DEATH December 11, 1968			2b. HOUR M		
3. SEX M		4. RACE W		5. DATE OF BIRTH 6-24-1883			6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Shenandoah, Pa.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor N. H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Signal Inspector			12b. KIND OF BUSINESS OR INDUSTRY Pa. RR.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N. J.			13b. COUNTY V. COUNTY		13c. CITY OR TOWN Point Pleasant		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1327 Sleepy Hollow Rd.		
14. FATHER'S NAME First Middle Last Jacob F. Hildenbrand				15. MOTHER'S MAIDEN NAME First Middle Last Hannah D. Moyer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 17-05-6499		17. INFORMANT Address Road Charles F. Hildenbrand, 803 Ridgeleigh						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>8-10 weeks</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>68</u> , to <u>12/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Joseph A. Sedlack, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>12/13/68</u>					
22d. PHYSICIAN'S NAME (Type) Dr. Joseph A. Sedlack						22e. ADDRESS 200 W. Penna. Ave.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/14/68		23c. NAME OF CEMETERY OR CREMATORY Atlantic View			23d. LOCATION (City or Town) (County) (State) Manasquan N. J.				
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto. 12, Md.						25a. REC'D BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1001

UNITED STATES

(200)

DEC 13 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print)			First Otto			Middle F.			Last Hoeflich			2a. DATE OF DEATH Month December Day 1, Year 1968			2b. HOUR 2:30 P.M.	
3. SEX M			4. RACE W			5. DATE OF BIRTH 7/19/1894			6. AGE (In years lost birthday) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.							
10. CITY OR TOWN OF DEATH Baltimore 21212			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6632 Loch Hill Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired - Sheet Metal Work			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore Balto. 12.			13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6632 Loch Hill Road							
14. FATHER'S NAME George			First Jacob			Middle Hoeflich			15. MOTHER'S MAIDEN NAME Josephine			First Freckman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-09-4987			17. INFORMANT Miss Bertha Hoeflich			Address (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMA</u> 149X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF THROAT</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 148X																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County		State			
22a. I certify that (1) (this hospital) attended the deceased from <u>3/6</u> , 19 <u>63</u> , to <u>12/1</u> , 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>11/26/68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>W. Meredith Smith M.D.</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12/2/68	
22d. PHYSICIAN'S NAME (Type) Dr. W. Meredith Smith			22e. ADDRESS 6305 The Alameda													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/5/68			23c. NAME OF CEMETERY OR CREMATORY Baltimore			23d. LOCATION (City or Town) Baltimore			(County) Md.			(State)	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			ADDRESS 4905 York Rd. Balto. 12, Md.			25a. REC'D BY REGISTRAR DEC 2 1968			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>							

IN RE: [illegible]  
[illegible]  
[illegible]

[illegible]  
[illegible]  
[illegible]

[illegible]  
[illegible]  
[illegible]

[illegible]  
[illegible]  
[illegible]

[illegible]  
[illegible]  
[illegible]

[illegible]  
[illegible]  
[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17093  
17093  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2 Burke Avenue</u>		d. STREET ADDRESS <u>2 Burke Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Matthew Lawrence</u> Middle <u>Holden</u> Last <u></u>		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1921</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co., Md.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Matthew Lawrence Holden</u>	
14. MOTHER'S MAIDEN NAME <u>Marion Flynn</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>218-12-4070</u>		17. INFIRMANT <u>Walter Ball, Parkville, Md. 21234</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4100</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Upper Respiratory Infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>3 yrs</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>68</u> , to <u>Dec 23 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 23 1968</u> , and that death occurred at <u>7:11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph A. Sedlacek</u>		22b. DATE SIGNED <u>12/25/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph A. Sedlacek</u>		22d. ADDRESS <u>200 W. Penna. Ave., Towson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 27, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Catholic Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Long Green, Balto. Co., Md.</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 31 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15023

CERTIFICATE OF DEATH

DEC 21 1958

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First <b>NELL</b>	Middle <b>PAULINE</b>	Last <b>HUDSON</b>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>		Month <b>December</b>	Day <b>23</b>	Year <b>19 68</b>	2b. HOUR <b>M</b>	
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>March 1, 1914</b>		6. AGE (In years last birthday) <b>54</b> YRS.	IF UNDER 1 YEAR MONTHS <b>54</b>		IF UNDER 24 HRS HOURS <b>54</b>		2c. DATE PRONOUNCED DEAD Month <b>December</b>		
7a. BIRTHPLACE (State or foreign country) <b>N. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>					
10. CITY OR TOWN OF DEATH <b>Middle River</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1214 Third Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Sewing Machine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1214 Third Road</b>			
14. FATHER'S NAME First <b>Robert McGuirt</b>		Middle <b></b>		Last <b></b>		15. MOTHER'S MAIDEN NAME First <b>Della Litaker</b>		Middle <b></b>		Last <b></b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>237 01 1688</b>		17. INFORMANT ADDRESS <b>Curtis D. Hudson 1416 Wilson Pt. Rd. Balto 20</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4221</b>											
19a. DATE OF OPERATION <b>4221</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12/24/68</b>	
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co., Md.</b>					
24. FUNERAL DIRECTOR <b>Bruzdinski Funeral Home</b>		ADDRESS <b>1407 Eastern Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

FOR STATE  
HEALTH DEPT.

17088

ANALYTICAL EXAMINER'S CERTIFICATE OF WEIGHT

STATION OF ANALYST: 515 N. 10TH ST. MINNAPOLIS, MINN. 55401

ANALYST'S SIGNATURE

LABORATORY SIGNATURE

237 OF 1000 COUNCIL ST. MINNAPOLIS, MINN. 55401

NO

Printed name of owner: 1407 Franklin Ave.

DEC 21 1988

Minneapolis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
17085										
17095										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
FRIEDA A. HUGHES						DEC 28 1968		10 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
F		W		MAR, 7, 1900		68 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MD		USA				BALTO.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
ESSEX			7503 RIDGLE AVE			HOUSE WIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.			BALTO.		ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7503 RIDGLE AVE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
GEORGE HETZ			ANNA EILTES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
VMS					JOHN T. HUGHES SR.		ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Pulmonary Emboli Sudden										
1830 DUE TO, OR AS A CONSEQUENCE OF Carcinomatosis 1 yr.										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF Carcinoma of ovary ?										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
1750										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
				MD		1968		Dec 28 1968		
22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 1968, to Dec 28, 1968, that (I) (we) last saw the deceased alive on Dec 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
G.M. Baumgardner						12/30/68				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
G.M. BAUMGARDNER						BALTO 21237				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		12/31/68		GARDENS OF FAITH		BALTO. MD				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.E. CONNELLY SONS				300 MACE		DATE JAN 2 1969		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR A M		
Nellie							Hurd		December 26, 1968		4:30 A		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		June 3, 1899				69 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland			USA					Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Towson			St. Joseph Hospital			Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland						Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		414 Hollen Rd. 21212			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
August					Rullman				Fannie			Colley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
						E. Arthur Hurd, 414 Hollen Road,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>5621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Diverticulitis with Peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>5721</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 24</u> , 19 <u>68</u> , to <u>Dec. 26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec. 26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Eugenio Antonio, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 12-26-68					
22d. PHYSICIAN'S NAME (Type) Eugenio Antonio, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			12/28/68		Parkwood Cemetery			Parkville, Md.					
24. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home 4210 Belair Road.						25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

11028

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17087

17097

1. DECEASED-NAME (Type or print) <b>PRESTON A. HUTCHINSON</b>			First Middle Last			2a. DATE OF DEATH DEC Month 29 Day 1968 Year			2b. HOUR 11A M					
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Aug. 18, 1907</b>			6. AGE (In years last birthday) <b>61</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>VA.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTO.</b>					
10. CITY OR TOWN OF DEATH <b>ESSEX</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>331 LORRAINE</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>TAVERN OWNER</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>			13c. CITY OR TOWN <b>ESSEX</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>331 LORRAINE</b>		
14. FATHER'S NAME <b>QUINTON HUTCHINSON</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>CLIMERIA AMIDON</b>			First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>UNK</b>			16b. SOCIAL SECURITY NO. <b>217-03-6911</b>			17. INFORMANT <b>EVELYN HUTCHINSON</b>			Address <b>ABOVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory failure.</b> <b>1619</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF <b>Extreme general weakness</b> (b) DUE TO, OR AS A CONSEQUENCE OF <b>Cancer of the Larynx</b> (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>161X</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>6 weeks.</b> <b>2 years.</b>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>October 10, 1968</b> , to <b>December 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>December 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Eugene C. Baumann</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>12-30-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Eugene C. Baumann</b>			22e. ADDRESS <b>413 Eastern Ave. Baltimore 21 Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12/31/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BELAIR</b>			23d. LOCATION (City or Town) (County) (State) <b>BELAIR MD.</b>					
24. FUNERAL DIRECTOR <b>J.B. CONNELLY SONS</b>			ADDRESS <b>300 MACE</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 2 1969</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

1. *[Faint, illegible text]*

2. *[Faint, illegible text]*

3. *[Faint, illegible text]*

4. *[Faint, illegible text]*

5. *[Faint, illegible text]*

6. *[Faint, illegible text]*

7. *[Faint, illegible text]*

8. *[Faint, illegible text]*

9. *[Faint, illegible text]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17088

17098

1. DECEASED-NAME (Type or print) <b>Catherine Ceceila Hylock</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>68</b>			2b. HOUR M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 25, 1914.</b>		6. AGE (In years last birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tailor</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3547 Woodring Ave</b>	
14. FATHER'S NAME First Middle Last <b>Emanuel Piraino</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Josephine Messina</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>213-01-2197</b>		17. INFORMANT Address <b>Mr. Kenneth Hylock 3306 Bayonne Ave. #14</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sebastian Russo</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/24/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Sebastian Russo M.D.</b>				22e. ADDRESS <b>5017 Harford Rd Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/28/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc Baltimore, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			



2019-01-10 10:00:00

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1. *Introduction*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>GIOVANNI</b>			First <b>D.</b> Middle <b>IAMPIERI</b> Last			2a. DATE OF DEATH Month <b>DEC</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR M
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>4-28-1881</b>			6. AGE (In years last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RIDGEWAY MANOR</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TAILOR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>930 ST. AGNES LANE</b>	
14. FATHER'S NAME First <b>UNKNOWN</b> Middle <b>IAMPIERI</b> Last			15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>215-03-7997</b>		17. INFORMANT <b>WILLIAM IAMPIERI</b> Address <b>5706 EDMONDSON AVE</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A.S.C.V.D.</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 12/30</b> , 19 <b>68</b> , to <b>12/30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. C. Pound</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>12/31/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>J. C. Pound</b>					22e. ADDRESS <b>3325 Frederick Ave</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-2-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR <b>WEBER FUNERAL HOME</b>					25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

17082

OFFICE OF THE ATTORNEY GENERAL

Case 3

JAN 3 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 7 & 8 Film 408											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12/31/68 kk 17090 CERTIFICATE OF DEATH 17100											
1. DECEASED-NAME (Type or print)			First		Middle		Last		20. DATE OF DEATH		
JAMES			JACKSON		12		Month 4		Day 68 Year		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)		
Male			Colored						59 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
unknown			unknown			unknown			Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
GARRISON, MD			Foxleigh Nursing Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD			Baltimore			Baltimore			1722 Division Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Myocardial infarction											
1621 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Bronchogenic carcinoma											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
1621											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 3, 1968, to Dec 4, 1968, that (I) (we) last saw the deceased alive on Dec 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Vicente M. Riquelme MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED Dec 4-68											
22d. PHYSICIAN'S NAME (Type) VICENTE M. RIQUELME 22e. ADDRESS Spring Green State Hospital											
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
REMOVAL			12.12.68			O. of Md. Med. School			Baltimore, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
						DEC 20 1968			J. Charles Judge		

07-71

07-10-71

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

17091										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17101									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last William Edgar JACOBS										Month 12 Day 23 Year 68										7:10 AM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Male			White			2/21/52			16 yrs. 10 mos.			MONTHS			DAYS			HOURS			MIN.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Washington			U.S.A.						Baltimore																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Owings Mills			Rosewood State			none			--																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																	
Maryland			Frederick			Frederick			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			212 N. Market St.																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
First Middle Last			First Middle Last																										
William Edgar JACOBS			Julia Lucretia SCHAEFFER																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																				
No			---			Rosewood Records, Owings Mills, Md.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																													
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <i>Bronchial obstruction</i>																													
513x DUE TO, OR AS A CONSEQUENCE OF																													
(b) <i>Ruptured Pulmonary Abscess</i>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
<i>Sever Mental Retardation, Institutionalized 12 yrs.</i>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			yes																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
			HOUR A.M. Month Day Year																										
			P.M.																										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No.			City or Town			County			State											
While <input type="checkbox"/> Not while <input type="checkbox"/>																													
at work <input type="checkbox"/> at work <input type="checkbox"/>																													
22a. I certify that (I) (this hospital) attended the deceased from <u>2/20/56</u> , 19 <u>  </u> , to <u>2/23/68</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>2/23/68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			22c. DATE SIGNED																										
<i>Richard L. Jones</i>			24 Dec 68																										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
Burial			12/27/68			Park Heights			Brunswick-Fred. Md																				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																				
<i>Leeta Funeral Home</i>			Brunswick-Md.			DATE DEC 31 1968			<i>g. Charles Judge</i>																				

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	<input type="checkbox"/> Day	<input type="checkbox"/> Year	2b. HOUR
John		Ward	Jeffries	12-19-68		10		8		M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
M	Cauc.	Aug. 27, 1896		72 YRS.	MONTHS		DAYS		Month	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		2d. HOUR
Baltimore		Md. U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore				M
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		13b. STREET AND NUMBER		14. Dalebrook Dr.		
Towson		St. Joseph		Martin Aircraft		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md		Baltimore		Phoenix		YES <input type="checkbox"/> NO <input type="checkbox"/>		14. Dalebrook Dr.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
T. Lucien Jeffries		Elizabeth Ward		No		212 22 3744		Mrs. Mildred Perego, Phoenix, Md.		21131
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4109		Coronary Occlusion		Sudden		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Chronic Emphysema		10+ yrs.				
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
21g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21i. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED		12/20/68						
ACTUAL SIGNATURE		Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)
EXAMINER'S NAME (Type)		Charles F. O'Donnell, M.D.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		Dec. 20, 68		Loudon		Baltimore, Baltimore, Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Wm. Cook-Brooks Towson, Towson, Md.				DEC 23 1968		Charles F. O'Donnell				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17093 CERTIFICATE OF DEATH 17103

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phie FFERS Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Talston Md</u>	
c. LENGTH OF STAY IN 1b <u>2 yr</u>		d. STREET ADDRESS <u>Records Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bradshaw Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE E Johnson</u>		4. DATE OF DEATH <u>12 16 1968</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 17 1902</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB H Johnson</u>		14. MOTHER'S MAIDEN NAME <u>NELLIE Mathews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>216-18-4940</u>	
17. INFORMANT <u>George Johnson</u>		Address <u>Bradshaw Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 2509 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis &amp; hypertension</u> DUE TO (c) <u>Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>25 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>67</u> , to <u>12-16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-15</u> , 19 <u>68</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Fred O. Hodous</u>		22b. DATE SIGNED <u>12-16-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Fred O. Hodous</u>		22d. ADDRESS <u>Edgewood Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-19-68</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Talston-NACOLE Cem</u>	23d. LOCATION (City, town or county) (State) <u>Talston Hartford Md</u>
24. FUNERAL DIRECTOR <u>George W Tittle Bel Air Md</u>		25a. REC'D BY REGISTRAR <u>DEC 17 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-64)  
30M REV. 1-66

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH			2b. HOUR		
17094 BERTHA JONES					12 Month 29 Day 1968 Year			M		
3. SEX F		4. RACE W		5. DATE OF BIRTH 1-6-1893		6. AGE (in years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1618 Elligson Rd			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Homemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY —		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2919 Hait Ave.		
14. FATHER'S NAME First Middle Last Christian R. Baesch				15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 215-22-9926		17. INFORMANT Address Samuel Jones 1618 Elligson Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE ARTERIOSCLEROTIC C.V. DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 NONE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-29-68 12-9-68 7-7-65		
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NONE				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. NONE		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NONE						
21d. INJURY OCCURRED While <input type="checkbox"/> at work at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) NONE		21f. LOCATION Street or R.F.D. No. City or Town County State NONE						
22a. I certify that (I) (this hospital) attended the deceased from 7-7-65, 19 to 12-29-1968, that (I) (we) last saw the deceased alive on 12-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. Schimunek MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-30-68
22d. PHYSICIAN'S NAME (Type) MANUEL A SCHIMUNEK MD				22e. ADDRESS 842 S. EAST AVE 31224						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-2-1969		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Balto. Md.				
24. FUNERAL DIRECTOR Thelma A. Hoffmann				ADDRESS 3218 Hudson St.		25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

2011

STATE OF TEXAS

© 2011 TEXAS STATE ARCHIVES

2011 STATE

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17095

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17105

1. DECEASED-NAME (Type or Print)		First CLAUDE		Middle JONES		Last JONES		2a. DATE KNOWN OF DEATH MATED		Month December		Day 21		Year 1968		2b. HOUR 7 A M							
3. SEX M	4. RACE C	5. DATE OF BIRTH 8/17/06		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month December		Day 21		Year 1968		2d. HOUR 7 A M							
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.															
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St Joseph		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Construct																	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY A A		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route 9															
14. FATHER'S NAME First Frank				Middle Jones				Last JONES				15. MOTHER'S MAIDEN NAME First Ida				Middle Moore				Last MOORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-01-3859				17. INFORMANT Mrs Lector Jones,				ADDRESS Same											
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Lung</u> 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of Stomach</u> DUE TO, OR AS A CONSEQUENCE OF 14yrt (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6+ Months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 151X																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County				State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 12/21/68				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 12/29/68				23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery				23d. LOCATION (City or Town) A A				(County) County				(State) Md			
24. FUNERAL DIRECTOR I Carroll, Halstead Funeral Home												ADDRESS 1206 W North Ave				25a. REC'D BY REGISTRAR DEC 23 1968				25b. REGISTRAR'S SIGNATURE Charles Judge			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17096

17106

1. DECEASED-NAME (Type or print) <b>HARRY FRANCIS KANE</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1968</b>			2b. HOUR <b>4:55 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 22, 1909</b>		6. AGE (In years last birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Doctor Physician</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>913 E. Belvedere Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Kane</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mrs Marie E Kane</b>			Address <b>Same</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT <b>Mrs Marie E Kane</b>		Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon with metastasis</b> <b>1538</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>1538</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/2/</b> , 19 <b>68</b> , to <b>12/5/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/5/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/6/68</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>L. J. Beck, Inc.</b>				ADDRESS <b>Balto, Md</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11100

STATE OF TEXAS

1903

IN SENATE,  
January 13, 1903.

REPORT OF THE

COMMISSIONER

OF THE

LAND OFFICE

FOR THE YEAR 1902

AND

1903

COMMISSIONER OF THE LAND OFFICE

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
FOR THE YEAR 1902  
AND 1903

1903

1902

1901

1900

1899

1898

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1902

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

1903

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
Item 6 Film 408 1/6/69 kk									
17107									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P M
ALFRED			ALBERT KEEFER			DECEMBER 28, 1968			12:30
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE		WHITE		10/17/1919			48 49 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND		U.S.A.					BALTIMORE		
1D. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
BALTO. TOWSON 4			ST. JOSEPH HOSPITAL			STEELWORKER			BETH. STEEL
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
MARYLAND 21234			BALTIMORE						13e. STREET AND NUMBER 1746 WHITE OAK ROAD
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Albin B. Keefer			Veronica Abbott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
yes WW11			176 16 9697			family records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cerebral Hemorrhage Right</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>443X</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 21,</u> 19 <u>68</u> , to <u>Dec. 28,</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec. 28,</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Christine Feliciano M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <u>DEC. 28, 1968</u>				
22d. PHYSICIAN'S NAME (Type) <u>Christine Feliciano M.D.</u>					22e. ADDRESS <u>7620 York Road, Towson 4, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		12/31/68		Moreland Memorial Pk		Balto. County, Md/			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C. F. EVANS & SON 8802 Harford Road					DATE <u>DEC 31 1968</u>		<u>J. Charles Judge</u>		

7011

DEC 31 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17098		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17108	
1. DECEASED-NAME (Type or print) First Middle Last HENRY M. KELLY					2a. DATE OF DEATH DEC Month 27 Day 1967 Year		2b. HOUR 4.30 M
3. SEX M	4. RACE W		5. DATE OF BIRTH March 6, 1879		6. AGE (In years last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Retired Plumber		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1351 N. Rolling Road		
14. FATHER'S NAME First Middle Last Bartholmew Kelly			15. MOTHER'S MAIDEN NAME First Middle Last Ellen Harding				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Kathleen F. Storey, 10 Montrose Manor Ct 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 493X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1 June, 1967</u> , to <u>12/27, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/26, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William C. Jordan</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. PHYSICIAN'S NAME (Type) <u>William C. Jordan MD</u> 22e. ADDRESS <u>1335 Suburban Pl-21227</u>						22c. DATE SIGNED <u>12/27/68</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-31-1968	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue 21229				25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEMORANDUM FOR THE DIRECTOR

DATE: 10-10-50

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

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[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>17099</div> <div>17109</div>																													
1. DECEASED-NAME (Type or print)						First			Middle			Last			2a. DATE OF DEATH			2b. HOUR											
Virginia						R			ice			KELLY			Month 12 Day 16 Year 1968			11:25 A M											
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.											
Female			White			8-15-1894						74 YRS.			MONTHS			DAYS											
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				Md.													
Maryland				U.S.A.								Baltimore																	
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY											
Towson						St. Joseph Hospital						Homemaker																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER											
Maryland												Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1711-D Waverly Way											
14. FATHER'S NAME						First			Middle			Last			15. MOTHER'S MAIDEN NAME						First			Middle			Last		
Anthony P. Rice															Mary Schmidt														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown						16b. SOCIAL SECURITY NO.						17. INFORMANT						Address											
No						217-48-6099						Mr. Robert J. Kelly						1963 White Oak Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Terminal carcinomatosis, primary in colon</u>																													
1538 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1538 (b) _____																													
DUE TO, OR AS A CONSEQUENCE OF (c) _____																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
Acute gastric dilatation																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (this hospital) attended the deceased from <u>12/16/</u> , 19 <u>68</u> , to <u>12/16/</u> , 19 <u>68</u> , that <u>NO</u> (we) last saw the deceased alive on <u>12/16/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Reynaldo Orjuela-Gomez, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>																		22c. DATE SIGNED <u>12/16/68</u>											
22d. PHYSICIAN'S NAME (Type) <u>Reynaldo Orjuela-Gomez, M.D.</u>																		22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)											
Burial						12/19/68						New Cathedral Cemetery						Baltimore, Maryland											
24. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Baltimore St.</u>																		25a. RECEIVED BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							
DATE <u>DEC 20 1968</u>																													

17109

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
171160					171110																		
1. DECEASED-NAME (Type or print)					First			Middle			Last			2a. DATE OF DEATH			2b. HOUR						
Helen Chilton Kenyon					Dec.			26			Year 68			2:15 P.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.								
Female			white			3-3-1876			92 YRS.			MONTHS 2			DAYS 10								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH														
Virginia			U.S.A.						Baltimore						Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY														
Baltimore County			Used Mens & Womans Home																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER											
604 E. 41st St.			-			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			604 E - 41st St.											
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First			Middle			Last		
Colin Chilton												Belle						Betts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address														
						Frances Shuckfus			615 Chestnut Ave.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) 4129 ASCVD.															years								
DUE TO, OR AS A CONSEQUENCE OF (b)																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
4221 Influenza																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 16, 1954, to Dec. 26, 1968, that (I) (we) last saw the deceased alive on Dec. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Newland E. Day MD															DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED December 24, 1968		
22d. PHYSICIAN'S NAME (Type) Newland E. Day, M.D.															22e. ADDRESS 4-E-33rd St Balto Md								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)														
Burial			12-30-68			Moriatto Church Cemetery			KILMARNOCK			Virginia											
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc															ADDRESS 1050 York Rd. Towson, Md. 21204			25a. REC'D BY REGISTRAR DATE DEC 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

1911

CENTRAL OF GEORGIA

1911

+ 2 C.D.

Impress

Miss E. D. May

H. C. Jones

DEC 30 1911

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>17101</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>171111</div>										
1. DECEASED-NAME (Type or Print) <b>FLOYD</b>			First Middle Last <b>E. KING</b>			2a. DATE KNOWN <input type="checkbox"/> Month Day Year <b>Dec. 7, 1968</b>		2b. HOUR OF ESTI- DEATH MATED <input type="checkbox"/> <b>7:30 AM</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>June 17, 1924</b>	6. AGE (In years last birthday) <b>44</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>Dec. 7, 1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>West Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>BALTO. Colmarville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Spring Grove State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>West Vir.</b>			13b. COUNTY <b>August</b>		13c. CITY OR TOWN <b>August</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>418 August</b>	
14. FATHER'S NAME First Middle Last <b>William King</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Minnie Saville</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 227-22-2362</b>		17. INFORMANT <b>Mrs. Pauline King</b>				ADDRESS <b>Augusta, West Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3032</b> <b>Chronic Alcoholism</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>3221</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <b>December 7, 1968</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Dec. 10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Augusta Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Augusta, Hampshire WVa.</b>				
24. FUNERAL DIRECTOR <b>Harry W. Haight Sykesville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

FOR THE  
RECORD

1511

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

1511

TO :	Mr. J. Edgar Hoover
FROM :	Mr. [illegible]
SUBJECT :	[illegible]
DATE :	June 12, 1964
RE :	[illegible]
BY :	[illegible]
CLASS :	[illegible]
FILE :	[illegible]
NOTES :	[illegible]

1511-52-512

Mr. J. Edgar Hoover

U. S. DEPARTMENT OF JUSTICE

RECEIVED

DEC 12 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17102										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17112				
Item 3 Film 408 1/8/69 kk										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Richard Middle Klausmeyer Last					2a. DATE OF DEATH Month 12 Day 27 Year 1968					2b. HOUR 7 40 A M									
3. SEX Female / Male					4. RACE White					5. DATE OF BIRTH November 11, 1892					6. AGE (In years last birthday) 76 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Baltimore, Md.									
10. CITY OR TOWN OF DEATH Towson					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) President					12b. KIND OF BUSINESS OR INDUSTRY Tire Sales									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. CITY OR TOWN Baltimore					13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER 510 Anneslie Rd.									
14. FATHER'S NAME First Middle Last Emil Klausmeyer					15. MOTHER'S MAIDEN NAME First Middle Last Francis Roth																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no ---					16b. SOCIAL SECURITY NO. 218-32-1214 A					17. INFORMANT Address Mrs. Helen E. Klausmeyer-510 Anneslie Rd.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>492x Cardio Respiratory Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>535x</u> (b) <u>Pulmonary Fibrosis and Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Acute tracheo-bronchitis</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (X) (this hospital) attended the deceased from <u>12-20</u> , 19 <u>68</u> , to <u>12-27</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>Reynaldo Orjuela-Gomez</u>										22c. DATE SIGNED 12/27/68					22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez									
22e. ADDRESS 6720 York Rd., Towson, Md. 21204																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 12/30/68					23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.					23d. LOCATION (City or Town) (County) (State) Balto. Co.									
24. FUNERAL DIRECTOR <u>Matchell W. Windolph</u>										25a. REC'D BY REGISTRAR JAN 3 1969					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

1111

RECEIVED

1111

TO THE DIRECTOR, FBI  
FROM THE DIRECTOR, FBI  
SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR THE DIRECTOR, FBI

[illegible]

[illegible]

[illegible]

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)			First GEORGE			Middle IRVING			Last KLEIN, JR.			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 19	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11/8/25	6. AGE (In years last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year December 1, 1968			2d. HOUR P. M.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.							
10. CITY OR TOWN OF DEATH Woodlawn			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) behind 7012 Bexhill Rd. (wooded area)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Fireman			12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 405 S. Beechfield Avenue			
14. FATHER'S NAME First Middle Last George I. Klein, Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Alberta Hampton			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes.						16b. SOCIAL SECURITY NO. W. W. T. 220-14-9598	
17. INFORMANT ADDRESS George I. Klein, Sr. 5516 Gunther Ave.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bronchopneumonia</u> 485 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 491 X EXPOSURE													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. ? P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Found in wooded area							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Woods			21f. LOCATION Street or R.F.D. No. Woodlawn			City or Town Baltimore		County State Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles S. Springate			EXAMINER'S NAME (Type) Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED December 2, 1968				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/4/68		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Ambrose Ino. 1328 Sulphur Sp Rd.						25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

17113

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1905

STATE OF  
NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17104

17114

1. DECEASED-NAME (Type or print) First Middle Last Henry J. Klein Jr.			2a. DATE OF DEATH Month Day Year 12 15 1968		2b. HOUR 2:30 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH 12-18-1915		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FIREMAN	12b. KIND OF BUSINESS OR INDUSTRY RAILROAD		
13a. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN PARKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8814 PEARL AVE	
14. FATHER'S NAME First Middle Last Henry J. Klein		15. MOTHER'S MAIDEN NAME First Middle Last Alice T. Kelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. NONE	17. INFORMANT Mildred Klein Address Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - Rupture 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease (Vessel) 4201 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. Sev. yrs.
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7-22-65, to 12-15-68, that (I) (we) last saw the deceased alive on 12-15-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Died at St. Joseph's Hospital.					
22b. SIGNATURE John C. Hyle			DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12-16-68
22d. PHYSICIAN'S NAME (Type) JOHN C. HYLE			22e. ADDRESS 2527 BREWER RD BALTIMORE 21236 MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-18-68	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION (City or Town) (County) (State) Cockeysville Md		
24. FUNERAL DIRECTOR CHAS. F. EVANS + Son		ADDRESS 8802 Harbor Rd	25a. REC'D BY REGISTRAR DATE DEC 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

41171

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

8801 21350

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> 17105  Item 5 Film 0107 12/23/68 wk </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH  DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div> <div> 17115 </div> </div>											
1. DECEASED-NAME (Type or print) <b>Henrietta J. Konitzky</b>						2a. DATE OF DEATH <b>Dec. 12.68</b> Month Day Year			2b. HOUR <b>5:30 P.M.</b>		
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>April 11/68</b> 1874 94			6. AGE (In years last birthday) <b>94</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Augsburg Luth Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4316 Bellview Ave.</b>		
14. FATHER'S NAME First Middle Last <b>John Henry Konitzky</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Marie Stueler</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown				16b. SOCIAL SECURITY NO. <b>213-50-7213</b>		17. INFORMANT Address <b>Records Aug. Luth Home 6811 Campfield</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senile Psychosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>2 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4200</b> <b>Generalized Arterio Sclerosis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>10</b> , 19 <b>63</b> , to <b>12/12</b> , 19 <b>68</b> , that (I) <b>(we)</b> lost <b>saw</b> the deceased alive on <b>Dec. 5 - 1968</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.											
22b. SIGNATURE <b>Earl L. Chambers M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <b>12/13/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Earl Chambers</b>						22e. ADDRESS <b>400-W. Cold Spring Lane Balto. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>			23d. LOCATION (City or town) (County) (State) <b>Balto Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>P.A. Heemann 6067 Harford Rd.</b>						25a. REC'D BY REGISTRAR <b>DEC 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

17115

CENTRAL OF MEXICO

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April 11, 1910

Mr. J. H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>17196</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>17116</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR a		
DOROTHY PEARL KOTLARZ						12 Month 14 Day 68 Year			1:40 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)		
FEMALE			CAUCASIAN			10-19-12			56 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
PENNA			U.S.A						BALTIMORE Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			GREATER BALTO. MED. CENT.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
md.			BALTIMORE			DUNDALK			2609 LIBERTY PKWY.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
STANLEY KRAWCZAK			PEARL DOBRO NIECKI								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
NO			NONE			NORBERT V. KOTLARZ			AS IN # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u> 2381										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 237X ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from 11-30, 19 68, to 12-14, 19 68, that (I) (we) last saw the deceased alive on 12-13, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul J. Edgar, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 12-14-68			
22d. PHYSICIAN'S NAME (Type) PAUL J. EDGAR								22e. ADDRESS 6701 N. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			12/17/68			SACRED HEART			BALTO. CO., MD.		
24. FUNERAL DIRECTOR <u>W. Brock Riedley, Overland, Md. 2122</u> ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
						DATE DEC 17 1968			<u>J. Charles Judge</u>		

11171

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17107

17117

1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Josephine		KOZEL		Month 12 Day 31 Year 1968		7 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White	March 15, 1885		85 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Czechoslovakia	U.S.A.			Baltimore, Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson	St. Joseph Hospital		HomemakerPacker		Langs Pidle Co		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland		Baltimore		6100 Bertram Ave.			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
John Brezina		Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
no		217-18-1626 A		Mary Westfall, sister, above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/17/1968, to 12/31/1968, that (I) (we) last saw the deceased alive on 12/31/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. ATTENDING PHYS. DEGREE		22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22e. DATE SIGNED	
Christina Feliciano, M.D.		7620 York Rd., Towson, Md. 21204				12/31/68	
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		1/3/69		Oak Hill Cemetery		Balto., Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home 3331 Brehms Lane 21213		DATE JAN 3 1969		J Charles Judge			



2000 2. HAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17108										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17118																													
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																			
WILLIAM										E. KRAMER										DEC										Month 18 Day 1968										8 45 AM									
3. SEX					4. RACE					5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR					IF UNDER 24 HRS.														
M					W					MAR. 21, 1905										63 YRS.										MONTHS					DAYS					HOURS					MIN.				
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. COUNTY OF DEATH										Md.									
MO.										USA																				BALTO.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																			
ESSEX										4 S. GOELLER AVE																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER									
MD.										BALTO										ESSEX										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										4 S. GOELLER AVE									
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																			
WILLIAM T. KRAMER																				DORA REDMERS																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																			
UNK																				JOHN YOUNGER										74 WILTSHIRE																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
2509										DUE TO, OR AS A CONSEQUENCE OF										Myocardial infarction										10 minutes																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)										Coronary insufficiency										3 years																			
										(c)										Diabetes, Arteriosclerosis.										Several years																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				260x Heart failure, chr. Liver cirrhosis																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
																				November 6, 1968 December 18, 1968																													
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on December 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE										Eugene C. Baumann										DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12-19-68																			
22d. PHYSICIAN'S NAME (Type)										Eugene C. Baumann										22e. ADDRESS 413 Eastern Ave Baltimore 21, Md																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
BURIAL										12/21/68										MORLAND										BALTO. MD.																			
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
J.G. CONNELLY SONS										300 MACE										DATE DEC 24 1968										J. Charles Judge																			

MEDICAL CERTIFICATION

81171

HYACINTH

171199

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Elvira Kruelle</b>			First Middle Last			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>68</b>			2b. HOUR <b>6.30</b> AM			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Apr. 24, 14</b>			6. AGE (In years last birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.						
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8317 Ridgley Oak</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teller</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8317 Ridgley Oak</b>			
14. FATHER'S NAME First Middle Last <b>Howard W. Shamleffer</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Carrie Bauer</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes, no, or unknown</b>			16b. SOCIAL SECURITY NO. <b>212-05-7159</b>		17. INFORMANT <b>Mathias Kruelle</b>			Address <b>Same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial lateral Sclerosis</b> <b>3480</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 min</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>3561</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1 May</b> , 19 <b>68</b> , to <b>14 Dec</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10 Dec</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>[Signature]</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>16 Dec 68</b>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>6604 Harford Rd. Balto (34) Md</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/17, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Faith</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>					
24. FUNERAL DIRECTOR <b>P.A. Heemann 6067 Harford Rd.</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>GEORGE</b>		First <b>M</b>		Middle <b>KURTZ</b>		Last		2a. DATE OF DEATH Month <b>Dec</b> Day <b>31</b> Year <b>68</b>			2b. HOUR <b>7:50 A</b>		
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>3-18-96</b>			6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>							
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BALTO. COUNTY GEN. HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>ASS'T TREASURER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.F.M.G.</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>RANDALLSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3734 OFFUTT RD</b>					
14. FATHER'S NAME First <b>GEORGE</b> Middle <b>W.</b> Last <b>KURTZ</b>		15. MOTHER'S MAIDEN NAME First <b>VIRGINIA</b> Middle <b>MITCHELL</b> Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-07-8584</b>		17. INFORMANT Address <b>DONALD J. KURTZ, 54 ACORN CIRCLE, Towson</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Brain Tumor - R. Post. Quad.</b> <b>2381</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>237X</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 16</b> , 19 <b>68</b> , to <b>Dec 31</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec 31</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Gregorio Marfori MD</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-31-68</b>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE <b>1-4-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Mausoleum</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>						
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>		ADDRESS <b>1050 York Road 21204</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

MEDICAL CERTIFICATION

KURTZ

BI

DATE

3-18-46

BALANCE

(MAY 1946)

WANDERSTON BAND, GUTHRIE, WY. 1946  
BARTO, RANDOLPH, WY. 1946  
JESSE DEWITT, WY. 1946

GEORGE

KURTZ

WILLIAM

NO 1  
JULY 1946 - 1947  
KURTZ, JESSE DEWITT, WY.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR								
MARGARET ANNE LAM						Month Day Year 12-31-68			7:10 PM								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.						
FEMALE		WHITE		6-4-1901			67 YRS.		MONTHS DAYS		HOURS MIN.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Virginia			U.S.A.						Baltimore								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of last year even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Towson			St. Joseph's Hospital			Housewife			None								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Baltimore			Towson			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			11 E. Chesapeake Ave. 04					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
First Middle Last			First Middle Last														
George Kyger			Gernie May Shifflett														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address								
NO			-----			Leonard Kyger			McGaheysville, Virginia								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Hepatic insufficiency</u>																	
571.9 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) <u>Cirrhosis of the liver</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
5810																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (X) (this hospital) attended the deceased from 9-29-68, 1968, to 12-31-68, that (X) (we) lost saw the deceased alive on 12-31-1968, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE												22c. DATE SIGNED					
Guilberto Gokim, Jr. M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												12-31-68					
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS					
Guilberto Gokim, Jr. M.D.												7620 York Road, Baltimore, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
Burial			1-2-1969			Mt. Olivet Cemetery			McGaheysville, Virginia								
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Wm. Cook-Brooks Towson 1050 York Road Towson 21204						DATE JAN 3 1969						f Charles Judge					

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Leo Michael Lambert						December 6, 1968			1:30 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		Feb. 23, 1885			83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Kentucky		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph Hospital			Retired		Printer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland					Baltimore				2922 Sylvan Ave. 21214
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John P. Lambert			Barbara Lutz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			217-03-0461		Mr. Lee E. Lambert 2206 Taylor Ave. 21234				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443X</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from <u>December 5, 1968</u> , to <u>Dec. 6, 1968</u> , that (A) (we) last saw the deceased alive on <u>December 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Francis T. Daly</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>12/6/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Francis T. Daly, M.D.</u>						22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Dec. 9, 68		Parkwood Cemetery		Parkville Maryland			
24. FUNERAL DIRECTOR <u>8728 Liberty Rd</u> <u>Loring Byers Funeral Home Randallstown, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17123

1. DECEASED NAME (Type or print) <b>Morris</b>		First		Middle		(LEMPER, LAMPELL)		2a. DATE OF DEATH Month <b>Dec</b> Day <b>6</b> Year <b>68</b>		2b. HOUR <b>1 A. M.</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>[REDACTED]</b>		6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>					
7a. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.									
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. Co. Gen. Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TAILOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6976 Mil Brook Pk Dr</b>							
14. FATHER'S NAME <b>hous</b>		First		Middle		Last		15. MOTHER'S MAIDEN NAME <b>Rachel</b>		First Middle Last <b>Fader</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b>		(If yes give war or dates of service) <b>W.W. I ARMY 056-01-6805</b>		16b. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT <b>MRS. NETTIE LAMPELL</b> <b>6976 MILBROOK PARK DR. #15</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>															
19a. DATE OF OPERATION <b>4201</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 3, 1968</b> , to <b>DEC 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>DEC 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Philip Bernstein</b>										DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-6-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Philip Bernstein, M.D.</b>										22e. ADDRESS <b>112 Chartley Dr., Reisterstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-8-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. HEBRON</b>		23d. LOCATION (City or Town) (County) (State) <b>Flushing, Long Island, New York</b>									
24. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

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CHURCH OF DEATH

IN DEPT. LANDS

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TO THE

STATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4  
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Theresa Marie LANDA						Month 12 Day 12 Year 1968		9:50 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		April 2, 1896		72 3/4 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Czechoslovakia		USA				Baltimore,		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				
Towson			St. Joseph Hospital			Homemaker				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		318 Townsend Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
CHARLES MRAZ			MARIE PALAK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NONE					MARIE URBAN					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) _____ DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (A) (this hospital) attended the deceased from <u>11/23/</u> , 19 <u>68</u> , to <u>12/12/</u> , 19 <u>68</u> , that (A) (we) last saw the deceased alive on <u>12/12/</u> , 19 <u>68</u> , and that in (our) (aur) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Samuel C.H. Lee, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED <u>12/12/68</u>										
22d. PHYSICIAN'S NAME (Type) <u>Samuel C.H. Lee, M.D.</u>					22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>					
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>12/16/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>				
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>		ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR <u>DATE DEC 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

4214

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1952

[Faint, mostly illegible text covering the main body of the document, possibly a letter or report.]

[Faint text, possibly a signature or name.]

[Faint text, possibly a date or reference.]

[Faint text at the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 14, 15, 16, 23 & 24  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Film G407 12/19/68 KK 17115

17125

1. DECEASED-NAME (Type or print) <b>Gladys I. Laubinger</b>			2a. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>4:15</b> P. M.				
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>March 20, 1910</b>		6. AGE (In years lost birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3810 Oglethorpe Street</b>	
14. FATHER'S NAME First Middle Last <b>Christopher G. Beadles</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Rose E. Turner</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>217-12-1583</b>			17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis with congestive ht. failure,</b> <b>472X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A2 Hong Kong Influenza (presumptive dx.)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>481X</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>none.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>July 5</b> , 19 <b>68</b> , to <b>Dec. 7</b> , 19 <b>68</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>Dec. 7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Anthony J. Young</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11 Dec 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>						22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland, Pr. Geo., Maryland</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons 4739 Balto. Ave. Hyattsville,</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

UNITED STATES OF AMERICA  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17116					17126						
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR			
Charles W Leiboldt					12 Month 29 Day 68			8:45A M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		May 13, 1897			71 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Smithsburg		USA.				Baltimore					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Owings Mills		Rosewood State Hosp.			None						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Washington		YES		Unknown			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Unknown				Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address				
No		---		Rosewood Records			Owings Mills, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X Respiratory insufficiency, bronchial obstruction										Terminal	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 475X										10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Pulmonary Disease										46 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Upper respiratory tract infection Mucous obstruction										terminal	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
institutionalized 68 yrs Chronic brain syndrome Etiology Unknown											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from 13 Aug 1968, to 29 Dec 1968, that (X) (we) last saw the deceased alive on 29 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Richard A. Jones M.D.		30 Dec 68		Richard A. Jones M.D.		Carroll County General Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/3/69		Rosewood Cemetery		Owings Mills, Md.					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. F. Line & Sons				Reisterstown, Md.		JAN 6 1969		James J. Jones			

14128

CERTIFICATE OF DEATH

14118



RECEIVED BY THE DEPARTMENT OF HEALTH

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17117

17127

1. DECEASED-NAME (Type or print) <b>FREDERICK</b>		First <b>E.</b>	Middle <b>E.</b>	Last <b>LEIMBACH</b>	2a. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1968</b>		2b. HOUR <b>2:55A</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUGUST 20, 1901</b>		6. AGE (In years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE,</b>			Md.
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Hardware Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2920 O'DONNELL ST. #21224</b>
14. FATHER'S NAME First Middle Last <b>George W. Leimbach</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Catherine Schreiber</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Margaret E. Schumann 627 Yarmouth Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201 DIABETES MELLITUS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from <b>December 11, 1968</b> , to <b>December 22, 1968</b> , that (X) (we) last saw the deceased alive on <b>December 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gualberto Q. Gokim, Jr.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED <b>DECEMBER 22, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>GUALBERTO GOKIM, JR., M.D.</b>		22e. ADDRESS <b>7620 YORK ROAD TOWSON, MD. #21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-24-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>17118</span> <span>CERTIFICATE OF DEATH</span> <span>17128</span> </div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
long			May			Lipscomb			Month Day Year 12 8 68
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		3-12-88			80 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
W.V.		USA					Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Arbutus			922 St. Charles Ave.			Homemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
W.V.			Dodridge			West Union		YES <input type="checkbox"/> NO <input type="checkbox"/>	412 Wood St.
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Hendrson Stutler				Ida May Kinney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				232096243-D		Freda Sahlin 922 St. Charles Ave. 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>									<u>Two</u>
4129 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arteriosclerotic CVD</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4221 <u>Rheumatoid arthritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/21</u> , 19 <u>68</u> , to <u>12/8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Herbert H. Levickas M.D.</u>		<u>12/8/68</u>							
22d. PHYSICIAN'S NAME (Print)		22e. ADDRESS							
<u>Herbert H. Levickas, M.D.</u>		<u>5404 East Drive</u>		<u>21227</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-12-68		West Union Mem. Cem.		West Union, W.V.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard 4107 Wilkens Ave. 21229				DATE DEC 16 1968		<u>Charles Judge</u>			

THE UNITED STATES OF AMERICA

DO hereby certify that

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>17119</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>17129</span> </div>											
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year			2b. HOUR M		
FRANCIS JOSEPH LITTLE						December 20 1968			5:30 P		
3. SEX		4. RACE		5. <del>September</del> August 9, 1922			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male		White		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			46 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Delaware		USA					Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph's Hospital			Crane Operator Chesapeake Crane					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1320 Meridene Drive		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MARRIAGE First Middle Last							
John J. Little				Mable B. Spangler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give date of discharge)				16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
yes W.W.2				218-12-0389		Charlotte M. Little			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lung disease</u> <u>519.2</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>527.2</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (a) (this hospital) attended the deceased from <u>Dec. 19</u> , 19 <u>68</u> , to <u>Decem. 20</u> , 19 <u>68</u> , that (b) (we) last saw the deceased alive on <u>December 20</u> , 19 <u>68</u> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Samuel C. H. Lee, M.D.</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>December 20, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>Samuel C. H. Lee, M.D.</u>						22e. ADDRESS <u>7620 York Road, Towson 4, Md.</u>					
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		12/23/68		Gardens of Faith			Balto. Md.				
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>						25a. REGISTRY DATE <u>DEC 23 1968</u>		25b. CLERK'S SIGNATURE <u>Charles J. [Signature]</u>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 16 & 17  
Film 0408  
7/6/69  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17130

1. DECEASED-NAME (Type or Print) First Middle Last GEORGE B LITTLE SR			2a. DATE KNOWN OF DEATH Month Day Year 12-23 1968			2b. HOUR OF ESTI- MATED 12 23 68	
3. SEX M	4. RACE W	5. DATE OF BIRTH 12/1/14	6. AGE (In years last birthday) 54 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 12 23 68	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 311 NICHOLSON RD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ELECTRICIAN		12b. KIND OF BUSINESS OR INDUSTRY STEEL	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 311 NICHOLSON RD		14. FATHER'S NAME First Middle Last WM LITTLE		15. MOTHER'S MAIDEN NAME First Middle Last ELSIE MOORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 211-01-3887		17. INFORMANT Helen Little-Wife ADDRESS MARIETTA AVE ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of LUNG- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 163X							
19a. DATE OF OPERATION April 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Biopsy - Scapular Nodes				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE M.B. Davis M.D. EXAMINER'S NAME (Type) M.B. DAVIS MORRINGTON RD ADDRESS 22b. DATE SIGNED 12/23/68							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/26/68		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		23d. LOCATION (City or Town) (County) (State) BALTO. MD	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS 300 MACE				25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

11130

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C. 20250

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C. 20250



PLANT INDUSTRY

DEC 30 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers numbered 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 11-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <b>EMMITT</b>			First <b>L.</b> Middle <b>LITTLETON</b> Last			2a. DATE OF DEATH <b>December 22<sup>nd</sup> 1968</b>			2b. HOUR <b>8:00</b> AM				
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>8-20-1894</b>			6. AGE (In years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>—</b> ✓			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2708 N. Howard St. #21218</b>		
14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>			15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>—</b>			16b. SOCIAL SECURITY NO. <b>215-22-6359</b>			17. INFORMANT <b>Wife - Vera</b> Address <b>same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Pulmonary Emphysema, Severe</b> <b>492X</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>5271</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>12-15-68</b> , 19 <b>68</b> , to <b>12-22</b> , 19 <b>68</b> , that <b>(H)</b> (we) last saw the deceased alive on <b>12-22</b> , 19 <b>68</b> , and that in <b>(M)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(H)</b> (we) (did) (didn't) view the body after death.													
22b. SIGNATURE <b>Samuel C. Lee, M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12-22-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Samuel C. Lee, M.D.</b>			22e. ADDRESS <b>7620 York Road, Towson, Md. #21204</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12/24/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>EAST NEW MARKET</b>			23d. LOCATION (City or Town) (County) (State) <b>E. NEW MARKET DORCHESTER</b>				
24. FUNERAL DIRECTOR <b>Paul E. Edwards</b>			ADDRESS <b>3615 Chestnut Ave.</b>			25a. DATE BY REGISTRAR <b>DEC 23 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

1047

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(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Edward</b>			First Middle Last			2a. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>1:05</b> PM
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 17, 1877</b>			6. AGE (In years last birthday) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b>			Md.
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>152 Springside Drive</b>
14. FATHER'S NAME First Middle Last <b>?</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>?</b>			Address <b>Timonium, Md.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>no</b> , or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>219-10-7740</b>		17. INFORMANT <b>Mrs. Edgar E. East, 152 Springside Dr.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease with</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4221</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/3/</b> , 19 <b>68</b> , to <b>12/9/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>12/9/</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lilia C. Baldonado</b>								22c. DATE SIGNED <b>12/9/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Lilia C. Baldonado, M.D.</b>					22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 11, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Parkville, Balto Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson Md</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17123

17133

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>M</b>		First		Middle		Last		2a. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>68</b>				2b. HOUR <b>M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH <b>12/2/68</b>				6. AGE (In years lost birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS <b>76</b> DAYS <b>76</b>		IF UNDER 24 HRS. HOURS <b>76</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO.</b> Md.							
10. CITY OR TOWN OF DEATH <b>TOWSON</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GBMC</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2009 East Bank Street</b>			
14. FATHER'S NAME First Middle Last <b>TERRY WILLIAM LOGUE</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>BRENDA KAY LOGUE</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>7762</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PULMONARY DYSPMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PREMATURITY</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>90 MIN</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7735</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>12/2</b> , 19 <b>68</b> , to <b>12/8</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>12/8/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Michael Bernstein M.D.</b> DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. <input type="checkbox"/>												22c. DATE SIGNED <b>12/8/68</b>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <b>6701 N. CHARLES STREET</b>							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <b>12/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harford Faith</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto Md</b>							
24. FUNERAL DIRECTOR <b>Wm Dally 322</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>					

MEDICAL CERTIFICATION

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81-32423

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 7&8 See birth cert. MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17124

CERTIFICATE OF DEATH

17134

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Baby Girl Lisa		Ann	Logue		12 Month 6 Day 68 Year		7:55 PM			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR			
Female	White		12/2/68		YRS. MONTHS DAYS		IF UNDER 24 HRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Baltimore		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Towson		Greater Balto Med. Center								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.		-----		Baltimore				2009 East Bank Street		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
TERRY WILLIAM				LOGUE	BRENDA KAY				LOGUE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary insufficiency</u> 7769 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Prematurity of birth</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7625								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 12/2/1968, to 12/6, 1968, that (I) (we) lost saw the deceased alive on 12/6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE								22c. DATE SIGNED		
Rudiger Breiteneker, M.D.								12/7/68		
22d. PHYSICIAN'S NAME (Type)		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22e. ADDRESS				
						6701 N. Charles Street				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12/9/68		St. Mary's of Faith		Balto - Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Leslie Della Noce		322 E. High St.		DEC 20 1968		J. Charles Judge				

28171

STATE OF NEW YORK

28171

DEC 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-69

MEDICAL CERTIFICATION

17125										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17135																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Emil G. Losch										Month Day Year December 23 1968										M																													
3. SEX M										4. RACE W										5. DATE OF BIRTH 9-21-1896										6. AGE (In years lost birthday) 72 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																			
10. CITY OR TOWN OF DEATH Halethorpe										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1808 Mayfield Avenue										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Paint Contractor										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Halethorpe										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 1808 Mayfield Avenue									
14. FATHER'S NAME First Middle Last Carl Losch										15. MOTHER'S MAIDEN NAME First Middle Last Wilamena (Unknown)										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No										16b. SOCIAL SECURITY NO. 218-10-8571										17. INFORMANT Hagerstown, Maryland 21740 Albert L. Losch, Paradise Church Rd. Rt 6									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crowning occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>suicide</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> , to <u>13 Dec 1968</u> , that (I) (we) last saw the deceased alive on <u>16 Dec 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE <u>William Goodman, M.D.</u> DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE, SIGNED 24 Dec 68																													
22d. PHYSICIAN'S NAME (Type) Dr. William Goodman										22e. ADDRESS 1334 Sulphur Spring Road																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 12-26-68										23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery										23d. LOCATION (City or Town) (County) (State) Balto. City, Baltimore, Md.																			
24. FUNERAL DIRECTOR Howard H. Hubbard										ADDRESS 4107 Wilkens Ave. 21229										25a. REC'D BY REGISTRAR DATE DEC 26 1968										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			

11112

REMARKS OF DEATH

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(1)

(2)

DEC 8 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17128

17136

1. DECEASED-NAME (Type or print) <b>BEULAH DEAL LOWDER</b>			First Middle Last			2a. DATE OF DEATH Month - Day - Year <b>12 - 23 - 1968</b>			2b. HOUR <b>4:30</b> PM		
3. SEX <b>FEMALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH <b>AUG. 13, 1903</b>			6. AGE (In years lost birthday) <b>65</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>		
10. CITY OR TOWN OF DEATH <b>DUNDALK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3473 LIBERTY PKWY</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SPoolER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>TEXTILE</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>DUNDALK</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>EDMOND M. DEAL</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>GEORGIA R. WALLER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			16b. SOCIAL SECURITY NO. <b>23 7-01-5396</b>		
17. INFORMANT <b>CLIFTON W. LOWDER</b>			Address <b>AS IN 10-11</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>aortic aneurysm, inoperable</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with tracheal obstruction</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4341</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> , 19 <b>62</b> , to <b>12/5</b> , 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>12/5</b> , 19 <b>68</b> , and that in <del>(my)</del> <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did not)</del> view the body after death.											
22b. SIGNATURE <b>Eugene F. Nevin</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>12.24.68</b>					
22d. PHYSICIAN'S NAME (Type) <b>EUGENE F. NEVIN, M.D.</b>			22e. ADDRESS <b>7001 MORNINGTON RD. DUNDALK, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>12/26/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>		
24. FUNERAL DIRECTOR <b>W. Brooks Buckley</b>			ADDRESS <b>Buckley, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>DEC 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



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JAN 20 1951  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17127

CERTIFICATE OF DEATH

17137

1. DECEASED-NAME (Type or print) <b>Henry</b>		First <b>A.</b>		Middle <b>Ludwig</b>		Last <b>Ludwig</b>		2a. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1968</b>				2b. HOUR <b>9:05</b> a. <b>a.</b> m. <b>M</b>					
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>April 24, 1902</b>				6. AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>					
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				Md.							
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>floor finisher</b>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Hamilton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7 Arizona Avenue</b>									
14. FATHER'S NAME First <b>Conrad H.</b> Middle <b>Ludwig</b>				15. MOTHER'S MAIDEN NAME First <b>Elizabeth Marie</b> Middle <b>Schmidt</b> Last <b>Schmidt</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-60-9339</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>severe urinary tract infection -</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>severe diabetic ulcers and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus.</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>260x Schizophrenia.</b>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1946</b> , to <b>Dec. 26, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Rafael H. Marin</b>												DEGREE <b>MD.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-26-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Rafael H. Marin, M.D.</b>				22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-1-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore City, Balto. Md.</b>									
24. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard 4107 Wilkens Ave., 21229</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>											

MEDICAL CERTIFICATION

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DEC 31 1953

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DEC 31 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 501 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17128 1. DECEASED-NAME (Type or print) First Middle Last <b>DONALD WARD LYON</b>					2a. DATE OF DEATH 12 Month 16 Day 68 Year			2b. HOUR 1 P.M.	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH 12-5-61		6. AGE (In years last birthday) 7 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.AA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT BALT MED CENTER</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>301 South Wind Rd.</b>	
14. FATHER'S NAME First Middle Last <b>James A Lyon</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Jean Hollingshead</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>James A. Lyon</b>		Address <b>301 South Wind Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5718</b> <b>MARKED FATTY METAMORPHOSIS OF LIVER WITH</b> DUE TO, OR AS A CONSEQUENCE OF <b>MARKED CEREBRAL EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>581.0</b> <b>NONE</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>68</u> , to <u>12/16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles C. Brown, M.D.</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/16/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>CHARLES C. BROWN, M.D.</b>		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>12/18/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>1st Reformed Cent</b>		23d. LOCATION (City or Town) (County) (State) <b>Pompton Plain NJ</b>			
24. FUNERAL DIRECTOR <i>W. H. Hall-Wiedefeld Home</i>				ADDRESS <b>6500 York Rd</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17139

17139

1. DECEASED-NAME (Type or print) <b>AMELIA</b>			First Middle Last <b>MAAG</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>68</b> <b>9:00 AM</b>			2b. HOUR		
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>6/1/88</b>			6. AGE (In years lost birthday) <b>80 YRS.</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>BAHo.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BAHo. County</b> Md.				
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Summit</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>retired clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>BAHo.</b>		13c. CITY OR TOWN <b>BAHo-28</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>6114 A-5 Edmond. AVE</b>		
14. FATHER'S NAME First Middle Last <b>August MAAG</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Hentelman ("athilda)</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>212-36-2662</b>		17. INFORMANT Address <b>BROTHER-6114A-5 Edmond. AVE</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>337X</b> (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>Year</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Previous C.V.A's.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Jan</b> , 19 <b>63</b> , to <b>Dec 10</b> , 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>12/17</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did)</b> (did not) view the body after death.											
22b. SIGNATURE <b>James J. Nolan</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>12/19/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. James J. Nolan</b>						22e. ADDRESS <b>1 Mallow Hill Road</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Witzke, 4101 Edmondson Ave., 21229</b>						25a. RECEIVED BY REGISTRAR DATE <b>DEC 23 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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CERTIFICATE OF DEATH

17130

17140

1. DECEASED-NAME (Type or print) <b>James M MacBrayne</b>		2a. DATE OF DEATH <b>12</b> Month <b>15</b> Day <b>68</b> Year		2b. HOUR <b>8</b> <sup>00</sup> <sub>a</sub> M	
3. SEX <b>Male</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>11/13/1889</b>	
7a. BIRTHPLACE (State or foreign country) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Great. Balt. Med. Cen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>	
14. FATHER'S NAME <b>Unknown</b>		15. MOTHER'S MAIDEN NAME <b>Unknown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Hans Odin</b> Address <b>7801 Beverly Rd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction and CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>7201</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>Dec. 4</b> , 19 <b>68</b> , to <b>Dec. 15</b> , 19 <b>68</b> , that <del>he</del> (we) lost saw the deceased alive on <b>Dec. 15</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.					
22b. SIGNATURE <b>Barry R. Friedlander MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/15/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Barry R. Friedlander M.D.</b>		22e. ADDRESS <b>6701 N. Charles St. 21204</b>			
23a. BURIAL CREMATION <b>Burial</b>		23b. DATE <b>12/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	
24. FUNERAL DIRECTOR <b>St. Neumann</b>		ADDRESS <b>6067 Hayford Rd</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17131												17141											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												1/8/69 kk											
Information taken from birth cert.												CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)				First MALE "A"				Middle MACEY				Last MACEY				2a. DATE OF DEATH 12 Month 29 Day 68 Year				2b. HOUR P 11:45 M			
3. SEX Male				4. RACE Cau.				5. DATE OF BIRTH 12/29/68				6. AGE (In years last birthday) — YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore, Md.											
10. CITY OR TOWN OF DEATH Baltimore, Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 3230 Rolling Road							
14. FATHER'S NAME First Middle Last Horace Thomas Macey, III				15. MOTHER'S MAIDEN NAME First Middle Last Kathleen Marie Schlining																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7826 Severe generalized edema - etiology undeter- mined. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7826												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 12/29, 19 68, to 12/29, 19 68, that (I) (we) lost saw the deceased alive on 12/29, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE Charles C. Brown, M.D.				22c. DATE SIGNED 12/29/68							
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.				22e. ADDRESS Greater Baltimore Medical Center																			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 12/31/68				23c. NAME OF CEMETERY OR CREMATORY Greater Balto. Med. Cen.				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland											
24. FUNERAL DIRECTOR Charles C. Brown, M.D.				ADDRESS				25a. REC'D BY REGISTRAR DATE JAN 8 1969				25b. REGISTRAR'S SIGNATURE Charles Judge											

1911

RECORD OF DEEDS

1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>17132</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 15 Film 408 1/6/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>17142</div>													
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR	
Marie				A. Madsen				Month 12 Day 29 Year 1968				3 15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		April 14, 1891				77 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Baltimore		USA				Baltimore, Md							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Towson			St. Joseph Hospital			Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2402 Lake Ave.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
John N. Suwalski				Margaret Krahn Kraning									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No				215-05-9877B		Mr. Peter J. Masden Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema secondary to arteriosclerotic cardiovascular disease</u>													
4129 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4221													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (A) (this hospital) attended the deceased from <u>12/29/</u> , 19 <u>68</u> , to <u>12/29/</u> , 19 <u>68</u> , that (A) (we) last saw the deceased alive on <u>12/29/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Camilo Tombac										12/29/68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
Camilo Tombac, M.D.						7620 York Rd., Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			1/2/69		New Cathedral Cemetery			Baltimore Maryland					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Leonard J. Ruck Inc.						JAN 2 1969			Charles Judge				
5305 Harford Road 21214													

MINISTRY OF DEFENSE

15703

11113

ALL

11113

John R. Sullivan

21-01-10718 Mr. John R. Sullivan

10

Thomas, George

1/2/9

Inspector J. Frank No. 5302 (Toronto Road 2121)

JAN 2 1909

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 4-68

171433										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17143																			
1. DECEASED-NAME (Type or print)										First Middle Last										20. DATE OF DEATH Month Day Year										2b. HOUR									
Katie										Manning										December 11 1968										6:50AM									
3. SEX Female					4. RACE Negro					5. DATE OF BIRTH Dec. 18, 1881					6. AGE (In years lost birthday) 86 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) Unknown					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Baltimore Md.																								
10. CITY OR TOWN OF DEATH Reisterstown					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bent Nursing Home					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic					12b. KIND OF BUSINESS OR INDUSTRY Private Homes																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Baltimore					13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER Unknown																			
14. FATHER'S NAME First Middle Last Thomas Menning					15. MOTHER'S MAIDEN NAME First Middle Last Martha Jones					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) Unknown										16b. SOCIAL SECURITY NO. 217-62-0322					17. INFORMANT Address Balto. City Welfare Dept. Records														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4409</u> <u>Constrictive Heart Failure - Chronic</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Brain Syndrome</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u> <u>Years</u>																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4500</u>																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>July 2</u> , 1967, to <u>December 11</u> , 1968, that (I) (we) last saw the deceased alive on <u>Dec 10</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE <u>C. E. McWilliams</u>										22c. DATE SIGNED <u>12-11-68</u>										22d. PHYSICIAN'S NAME (Type) C. E. McWilliams					22e. ADDRESS <u>11908 Reisterstown Rd. Reisterstown Md.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE Dec. 13, 1968					23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery					23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland.																								
24. FUNERAL DIRECTOR <u>H. J. Ebhardt</u>										ADDRESS Owings Mills, Md.										25a. REC'D BY REGISTRAR DATE <u>DEC 16 1968</u>					25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>														

MEDICAL CERTIFICATION

CONTINUATION OF REPORT

1. Name of the person or organization to whom the report is made: [illegible]  
2. Name of the person or organization making the report: [illegible]  
3. Title of the report: [illegible]  
4. Date of the report: [illegible]  
5. Place of the report: [illegible]  
6. Nature of the report: [illegible]  
7. Summary of the report: [illegible]  
8. Details of the report: [illegible]  
9. Conclusion of the report: [illegible]  
10. Signature of the person making the report: [illegible]  
11. Signature of the person to whom the report is made: [illegible]  
12. Date of the signature: [illegible]  
13. Place of the signature: [illegible]  
14. Other information: [illegible]



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED		2b. HOUR	
Karan			Vicari			Marshall		December 22, 1968 6:15 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	
Female	White	1-21-68	11 YRS.	11 1				December 22, 1968 6:15 P.M.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland			U.S.A.					Baltimore Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph Hospital						
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Baltimore			Parkville		13e. STREET AND NUMBER 1311 Kenton Rd.-21234	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			
Stanley			Marshall Jr.			Mary Marshall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury To Brain Stem</u> DUE TO, OR AS A CONSEQUENCE OF <u>880X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 Day</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>9000</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:00 P.M. December 21, 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Ran Kiddie Car down 11 Steps			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State 1311 Kenton Rd 21234 Parkville Baltimore Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Charles F. O'Donnell, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/22/68	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL			DEC. 23, 1968			HOLY ROSARY CEM.		PUNDALK, BALTO. CO., MD.	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
John Burns' Sons, Towson, Md.			DEC 31 1968			Charles Judge			

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

NO. 1000  
MAY 1914

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/69

17135

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17145

1. DECEASED-NAME (Type or print)		First <b>Sharon</b>	Middle <b>Lynn</b>	Last <b>MARSHALL</b>	2a. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1968</b>		2b. HOUR <b>9:30 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-9-1968</b>		6. AGE (In years lost birthday) YRS. <b>6</b> MONTHS <b>43</b> DAYS <b>43</b>		IF UNDER 1 YEAR MONTHS <b>6</b> DAYS <b>43</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b>			Md.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1311 Kenton Rd.</b>		
14. FATHER'S NAME First <b>Stanley</b> Middle <b>Marshall</b> Last <b>Marshall</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Vicari</b> Last <b>Noppenberger</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give year of dates of service)		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Family records -</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> <b>777X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>776X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>12/9/</b> , 19 <b>68</b> , to <b>12/9/</b> , 19 <b>68</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>12/9/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Imelda Salanio</b>		22c. DATE SIGNED <b>12/9/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Imelda Salanio, M.D.</b>		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

MEDICAL CERTIFICATION

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RECEIVED

12-2-50

11-1-50

2217

17136

## CERTIFICATE OF DEATH

17146

1. DECEASED-NAME (Type or print) <b>M A R Y      M A R T I N</b>			First      Middle      Last			2a. DATE OF DEATH <b>December 30, 1968</b>			2b. HOUR <b>4:00 P.M.</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>May 18, 1893</b>			6. AGE (In years last birthday) <b>75</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Lithuania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>710 Charing Cross Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tailor</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Catonsville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>Unknown</b>			First      Middle      Last			15. MOTHER'S MAIDEN NAME <b>Magdalen Rimkus</b>			First      Middle      Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Miss Dorothy Martin, 710 Charing Cross Rd.</b>			Address <b>21229</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>443X</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M.      Month      Day      Year P.M.      19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work      at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.      City or Town      County      State					
22a. I certify that (I) (this hospital) attended the deceased from <u>8-21-</u> 19 <u>67</u> , to <u>Dec 30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harry L. Knipp, MD</u>						22c. DATE SIGNED <u>1-2-69</u>			22d. PHYSICIAN'S NAME (Type) <b>Dr. Harry L. Knipp</b>		
22e. ADDRESS <b>4116 Edmondson Avenue, Balto., Md.</b>						22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22g. REC'D BY REGISTRAR		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>1-3-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR. <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>						25a. REC'D BY REGISTRAR <b>JAN 6 1969</b>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00151

STATE OF NEW YORK

1911

100

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
CHARLES WILBER MAUSE					December 14 <sup>th</sup> 1968		7.40PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		5-22-13		55 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland	U.S.A.				Baltimore			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson	St. Joseph Hospital		Radar Tech. Bendix Radio Corp.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland	V		Baltimore				924 Wilmot Ct.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT
Charles Mouse		Georgia Zollner						Mr. Laurie C. Mause, 821 N. Glover St. 21205
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro Intestinal Hemorrhage</u> <u>5339</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Peptic Ulcer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Possible Cerebral Hemorrhage</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>5400</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-21-</u> , 19 <u>68</u> , to <u>12-14-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-14-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Camilo Z. Tomboc</u>				22c. DATE SIGNED 12-14-68		22d. PHYSICIAN'S NAME (Type) Camilo Z. Tomboc MD.		
22e. ADDRESS 7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		12/19/68.		Oak Lawn Cemetery		Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO DEPUTY MEDICAL EXAMINER:**  
necessary, please execute the certificate of death and return it to the funeral director. Page 4 should be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

17138												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												17148											
1. DECEASED-NAME (Type or Print) First Middle Last Grayson Early Mc Allister												2a. DATE KNOWN OF DEATH Month Day Year 12-26 68												2b. HOUR 6A. M.											
3. SEX Male				4. RACE White				5. DATE OF BIRTH March 30, 1911				6. AGE (In years last birthday) 57 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				2c. DATE PRONOUNCED DEAD Month Day Year December 26, 1968				2d. HOUR 12P. M.											
7a. BIRTHPLACE (State or foreign country) Virginia				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore Md.																							
10. CITY OR TOWN OF DEATH Dundalk				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4128 Old North Point Road				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Service Station Attendant				12b. KIND OF BUSINESS OR INDUSTRY																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Dundalk				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 4128 Old North Point Road																			
14. FATHER'S NAME First Middle Last Richard Mc Allister				15. MOTHER'S MAIDEN NAME First Middle Last Lillian ?																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 219-12-9634				17. INFORMANT (Sister) Mrs. Joseph Morris, 3713 Old North Point Rd.				ADDRESS Dundalk, Md.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OH-S-C-V- DISEASE</u> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																																			
ACTUAL SIGNATURE Melvin B. Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ADDRESS (Street, city, town, or county) Dundalk, Md. 21222				22b. DATE SIGNED 12/26/68 6800 Mornington Rd.																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 12/29/68				23c. NAME OF CEMETERY OR CREMATORY Prize Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Boonesville, Albemarle Co. Va.																							
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				ADDRESS				25a. REC'D BY REGISTRAR DEC 30 1968				25b. REGISTRAR'S SIGNATURE Charles Judge																							

15158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John J. Smith		45		Male		White		1930		New York	
Cause of Death		Disease		Symptoms		Manner of Death		Time of Death		Signature of Examiner	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		Natural		10:00 AM		J. J. Smith	
Occupation		Education		Marital Status		Previous Illnesses		Heredity		Remarks	
Teacher		High School		Married		None		None		None	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker	
J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>17138</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>17149</span> </div>									
1. DECEASED-NAME (Type or print) <b>OTIS LEE MC CONKEY</b>					2a. DATE OF DEATH <b>DEC. Month 9 Day 1968</b>			2b. HOUR <b>M</b>	
3. SEX <b>male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH <b>Oct. 13, 1922</b>		6. AGE (In years lost birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Tec. Eng.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>T.V.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Phoenix</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Princess Anne Way</b>	
14. FATHER'S NAME First Middle Last <b>Charles McConkey</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary A. Shaley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>4109 1942-1946</b>		17. INFORMANT Address <b>Elizabeth McConkey Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary atherosclerosis</b> (c) <b>10 yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>59</b> , to <b>oct</b> , 19 <b>68</b> ; that (I) (we) last saw the deceased alive on <b>24 oct</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Abraham Genecin</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>12/9/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Abraham Genecin, M.D.</b>				22e. ADDRESS <b>611 1/2 Park Ave.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-11-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Floral Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>High Point, N. C.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR			
DENNIS			JOHN		McCORMACK				DECEMBER 30, 1968		8:30 p M			
3. SEX			4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE			WHITE		6/26/04				64 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
SCOTLAND			U.S.A.					BALTIMORE Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD			VETERANS ADMIN. HOSPITAL					CARPENTER			CONSTRUCTION			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
MARYLAND			BALTIMORE		Fort Howard BALTIMORE				Box 280A, Route 10					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last		
JOHN			--		McCORMACK				MARGARET			-- McDUGALL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
YES			1922 - 1925		213 07 51 04		CLINICAL RECORDS, VAH, FT. HOWARD, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST											HOURS			
4109 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION											UNKNOWN			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) --														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
-- 4201														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that <del>he</del> (this hospital) attended the deceased from DEC 6, 1968, to DEC 30, 1968, that <del>he</del> (we) last saw the deceased alive on DEC 30, 1968, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>he</del> (we) (did) <del>not</del> view the body after death.														
22b. SIGNATURE <i>Peter Juwan</i>											DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/30/68	
22d. PHYSICIAN'S NAME (Type) PETER V. JUWAN, M.D.											22e. ADDRESS VAH, FT. HOWARD, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
BURIAL			1/13/69		BALTO. NATIONAL CEMETERY			BALTIMORE, MARYLAND						
24. FUNERAL DIRECTOR														
JOHN J. DUDA														
ADDRESS 7922 WISE AVE. BALTO., MD.														
25a. DEATH BY REGISTRAR JAN 2 1969														
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>														

VR 43/69  
45-11-69

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Harold Arthur Mc Cormick			2a. DATE OF DEATH Month Day Year 12 29 1968			2b. HOUR 5A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-9-1906		6. AGE (In years lost birthday) 62 YRS.	
7a. BIRTHPLACE (State or foreign country) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Md.	
10. CITY OR TOWN OF DEATH Phoenix		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Phoenix Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manufacture's Rep.		12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Phoenix		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Phoenix Rd. (Rural)		14. FATHER'S NAME First Middle Last Wm. Arthur Mc Cormick		15. MOTHER'S MAIDEN NAME First Middle Last Carlisle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes 1924-1930		16b. SOCIAL SECURITY NO. 091-09-0257		17. INFORMANT Wife		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coranary Occlusion</u> <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coranary Scleroëis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>5 Years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>person</del> attended the deceased from <u>7</u> , 19 <u>48</u> , to <u>12</u> , 19 <u>68</u> , that (I) <u>(X)</u> last saw the deceased alive on <u>12-26</u> , 19 <u>68</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(X)</u> (did) <u>(did not)</u> view the body after death.							
22b. SIGNATURE <u>Walter T. Kees</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-30-1968	
22d. PHYSICIAN'S NAME (Type) Walter T. Kees				22e. ADDRESS Cockeysville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <u>1-3-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>XXXXX-2-1968 Arlington Nat'l Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. Towson				25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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CERTIFICATE OF DEATH

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17152

1. DECEASED-NAME (Type or print) <b>Leo</b>		First <b>Leo</b>	Middle <b>J.</b>	Last <b>McDermott</b>	2a. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1968</b>		2b. HOUR <b>4:40</b> M				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>June 27, 1918</b>		6. AGE (In years last birthday) <b>50</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>highway workman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1505 Woodbourne Avenue</b>			
14. FATHER'S NAME First <b>Albert J. McDermott</b>		Middle <b>Albert J. McDermott</b>		Last <b>Albert J. McDermott</b>		15. MOTHER'S MAIDEN NAME First <b>Irene</b>		Middle <b>Luthhardt</b>		Last <b>Luthhardt</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>220-01-6901HA</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>Records: SPRING GROVE STATE HOSPITAL</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>492X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <b>Upper respiratory infection.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Emphysema</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>527.1 Chronic Disinfection.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from <b>Sept. 15, 1967</b> to <b>Dec. 26, 1968</b> , that (we) last saw the deceased alive on <b>Dec. 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Rafael H. Marin, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-26-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Rafael H. Marin, M.D.</b>				22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/28/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				ADDRESS <b>Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR 418 (4)  
45M - 1-69

<div>17143</div> <div> <div>1</div> <div>4</div> </div> <div> <div>17153</div> <div>1</div> </div>																							
<div> <div> <div>17143</div> <div>1</div> </div> <div> <div>4</div> <div>1</div> </div> <div> <div>17153</div> <div>1</div> </div> </div>																							
1. DECEASED-NAME (Type or print)				First <b>WILLIAM</b>				Middle <b>LEO</b>				Last <b>MC DONOUGH</b>				2a. DATE OF DEATH Month <b>12</b> Day <b>4</b> Year <b>68</b>				2b. HOUR <b>10:00AM</b>			
3. SEX <b>MALE</b>				4. RACE <b>WHITE</b>				5. DATE OF BIRTH <b>9/9/97</b>				6. AGE (In years lost birthday) <b>71</b> YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign) <b>BALTIMORE, MD.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md.											
10. CITY OR TOWN OF DEATH <b>FORT HOWARD, MARYLAND</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FILE &amp; MARBLE SETTER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>—</b>				13c. CITY OR TOWN <b>BALTIMORE</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER <b>2707 E. Jefferson Street</b>							
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>MC DONOUGH</b> Last <b>—</b>				15. MOTHER'S MAIDEN NAME First <b>HONNORA A.</b> Middle <b>O'MALLEY</b> Last <b>—</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give war or dates of service) <b>WW I</b>				16b. SOCIAL SECURITY NO. <b>213 21 22 66</b>				17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE, FAR ADVANCED</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4200</b>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO AUTOPSY</b>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (a) (this hospital) attended the deceased from <b>11/20/68</b> , 19 <b>68</b> , to <b>12/4/68</b> , 19 <b>68</b> , that (b) (we) last saw the deceased alive on <b>12/4/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <b>Erhard J. Bunyor MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>												22c. DATE SIGNED <b>12/4/68</b>											
22d. PHYSICIAN'S NAME (Type) <b>ERHARD J. BUNYOR, M. D.</b>												22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>12-7-68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>											
24. FUNERAL DIRECTOR ADDRESS <b>JOHN A MILLER FUNERAL HOME</b> <b>2334 E. Jefferson St. Baltimore, Md.</b>																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Item 13 Film 407 12/16/68												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17154							
17144												CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Elizabeth K. McGuire</i>						First <i>K.</i> Middle <i>McGuire</i> Last						2a. DATE OF DEATH <i>Dec. 7, 1968</i>						2b. HOUR <i>M</i>					
3. SEX <i>female</i>				4. RACE <i>white</i>				5. DATE OF BIRTH <i>Nov. 13, 1886</i>				6. AGE (In years last birthday) <i>82</i> YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Baltimore</i> Md.											
10. CITY OR TOWN OF DEATH <i>Rodgers Forge</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Armcast Nursing Home</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>				13b. COUNTY <i>Baltimore</i>				13c. CITY OR TOWN <i>Rodgers Forge</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER <i>127 W Glover St. 812 / Register Ave. 21221</i>							
14. FATHER'S NAME First <i>Uriah</i> Middle <i>Foster</i> Last						15. MOTHER'S MAIDEN NAME First <i>Not known</i> Middle Last																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. <i>21554261791</i>				17. INFORMANT <i>Charles W. McGuire</i> Address <i>5006 Loch Raven Bl v</i>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gulmonary Edema</i> <i>4120</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Spontaneous Atherosclerotic</i> <i>Cardio Renal Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF <i>10 yrs</i> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>32 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>442 X</i>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 10, 1965</i> to <i>Dec 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>December 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>Charles F. O'Donnell</i> DEGREE <i>MD</i>												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/8/68</i>									
22d. PHYSICIAN'S NAME (Type) <i>Charles F. O'Donnell</i>												22e. ADDRESS <i>7501 York Road Baltimore, Md. 04</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>12-11-68</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>											
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i> ADDRESS												25a. REC'D BY REGISTRAR <i>DEC 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

17154

CERTIFICATE OF DEATH

17154

Blank certificate form with horizontal lines for text entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

<div style="display: flex; justify-content: space-between;"> <span>171155</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>17155</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>																	
1. DECEASED-NAME (Type or print)			First MARY			Middle ANN			Last MC PHERSON			20. DATE OF DEATH Month December 21 Day 1968 Year			2b. HOUR 8:50 M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 10-12-19			6. AGE (In years lost birthday) 49 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
70. BIRTHPLACE (State or foreign country) Georgia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.								
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home								
130a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 14 E. Lake Avenue #21212					
14. FATHER'S NAME First J. Middle R. Last McCalla			15. MOTHER'S MAIDEN NAME First Unknown Middle Last														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. --			17. INFORMANT Edwin McPherson Address 14 E. Lake Ave., Balto								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lung disease</u> <u>5192</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>5272</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12-21</u> , 19 <u>68</u> , to <u>12-21</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12-21-68</u> 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>William</u>			DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-21-68											
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.			22e. ADDRESS 7620 York Road, Towson 4, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-24-68			23c. NAME OF CEMETERY OR CREMATORY Oakhill			23d. LOCATION (City or Town) (County) (State) Newman Ga.								
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			ADDRESS 4905 York Rd., Balto			25a. REC'D BY REGISTRAR DATE DEC 24 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

MEDICAL CERTIFICATION

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17146

**CERTIFICATE OF DEATH**

17156

1. DECEASED-NAME (Type or print) <b>Alice</b>			First <b>Mae</b>			Middle <b>Meeks</b>			Last			2a. DATE OF DEATH December <sup>Month</sup> 8 <sup>Day</sup> 1968 <sup>Year</sup>			2b. HOUR M		
3. SEX <b>F</b>			4. RACE <b>W</b>			5. DATE OF BIRTH <b>April 19, 1880</b>			6. AGE (In years lost birth) <b>88</b> YRS.			IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>			IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.								
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Ridgeway Manor</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Housekeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Catonsville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>441 Chalfonte Drive 21228</b>					
14. FATHER'S NAME <b>William Meeks</b>			First <b>William</b>			Middle <b>Meeks</b>			Last			15. MOTHER'S MAIDEN NAME First <b>Eliza R. Wilson</b>			Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-34-8744</b>			17. INFORMANT <b>Margaret R. Mund</b>			Address <b>Catonsville</b>			441 Chalfonte Drive 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>486X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>493X</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>William Goodman</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>Dec 6 1968</b>								
22d. PHYSICIAN'S NAME (Type) <b>William Goodman</b>			22e. ADDRESS <b>1334 Sulphur Spring Rd., Baltimore 21227</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12-11-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Edmondson ave., Balto. Md.</b>								
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>			ADDRESS <b>4107 Wilkens Avenue, Balto.</b>			25a. REC'D BY REGISTRAR <b>DEC 11 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11136

UNITED STATES OF AMERICA

11136

NOV 10 1964

TO THE DIRECTOR, FBI

FROM THE SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

NY 100-11136

NY 100-11136

NY 100-11136

NY 100-11136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <span>17147</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>17157</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>															
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR			
MATTHEW				H. MEIGHAN				Month Day Year December 5, 1968				PM 11:10			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		2-16-1898				70 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
New York		U.S.A.				Baltimore Md.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Towson		St. Joseph Hospital				Priest				Redemptorist Fathers					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
New York						N.Y. City				173 E. 3rd. St. #10009					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
Lawrence Meighan				Catherine Schlitt											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) W.W.II				16b. SOCIAL SECURITY NO. 118-40-8718		17. INFORMANT Address Rev. George Rosenkranz C.S.S.R Same.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>															
4109 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u>															
(b) <u>Severe coronary arteriosclerosis</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
<u>Diabetes mellitus</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>November 30, 1968</u> , to <u>December 5, 1968</u> , that (I) (we) lost saw the deceased alive on <u>December 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Lawrence F. Misanik</u>												DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/6/68	
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.												22e. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-10-68		23c. NAME OF CEMETERY OR CREMATORY Mt. St. Alphonsus Cem.				23d. LOCATION (City or Town) Esopus, (County) New York. (State)							
Burial															
24. FUNERAL DIRECTOR Charles S. Geiler		901 S. Conkling St. Balto., 21224, Md.		25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

73171

STANDARD OF TOWN

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VR A15 (4)  
25M 1/67

17148

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 1 & 2 Film 408 1/2/69 kr

CERTIFICATE OF DEATH

17158

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>6 mos.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>				d. STREET ADDRESS <u>FA. Howard Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Merrick</u> Middle <u>Merrick</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1968</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-04</u>	9. AGE (In years last birthday) yrs. <u>64</u>	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Newport News, VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Frank Merrick</u>			14. MOTHER'S MAIDEN NAME <u>Adelle Mayes</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW2</u>			16. SOCIAL SECURITY NO. <u>217-01-2644</u>		17. INFORMANT <u>James E. Merrick</u> Address <u>823 W. Salisbury St</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>2509</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.C.V.D. - MYELOCYTHAEMIA</u> DUE TO (c) <u>DIAGNOSIS UNKNOWN</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> , 19 <u>68</u> , to <u>12/24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>68</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John H. Shaw</u>						22b. DATE SIGNED <u>12/26/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>			22d. ADDRESS <u>5801 SPANGLER AVE. BALDWIN</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bella Hallona Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Bella Hall</u>	
24. FUNERAL DIRECTOR <u>Williams Funeral Home</u>				25a. REC'D BY REGISTRAR <u>DEC 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11158

RECEIVED



(10)

11158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17149

CERTIFICATE OF DEATH

17159

1. DECEASED-NAME (Type or print) <b>Jennie</b>			First Middle Last <b>Meyer</b>			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> , Year <b>1968</b>			2b. HOUR <b>8 A M</b>		
3. SEX <b>female</b>			4. RACE <b>white</b>			5. DATE OF BIRTH <b>Jan. 22, 1882</b>			6. AGE (In years last birthday) <b>86</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Rodgers Forge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>404 Hopkins Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Wolfgang</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Jennie Lexstein</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mrs. Bernice Foard</b>			Address <b>404 Hopkins Rd. #21212</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>apoplexy.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>old age &amp; arterio sclerosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1968</b> to <b>Dec 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 7, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <b>M Paul Byrd</b>			DEGREE <b>M Paul Byrd</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>12-7-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>M Paul Byrd</b>			22e. ADDRESS <b>5820 York Rd</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/11/68</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>			24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>			ADDRESS <b>6500 York Rd. #21212</b>		
25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			VR A15 (4) 45M - 1/69					

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17150

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17160

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
WILLIAM			MEYER, JR			19			M						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
Male		White		12--6-07		61 YRS.		MONTHS DAYS		HOURS MIN		December Day 13 Year 19 68			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. COUNTY OF DEATH			
Maryland			U.S.A.			WIDOWED			DIVORCED			BALTIMORE Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Dundalk, Maryland				8221 Watersedge Road Packer								National Can			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Md.				Baltimore				Dundalk				YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				17. INFORMANT ADDRESS							
First Middle Last				First Middle Last				Mrs. Emily Wendelstedt, 3435 Dunran Road 21222							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
Yes				W W II				214-05-3154							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
4221															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?					
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>					21b. TIME OF INJURY Month, Day, Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH					19 P.M.										
21d. INJURY OCCURRED					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE					Charles S. Springate, M.D.					22b. DATE SIGNED					
EXAMINER'S NAME (Type)										December 14, 1968					
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					
BURIAL					12-17-1968					Moreland Memorial Park					
24. FUNERAL DIRECTOR					ADDRESS					25a. REC'D BY REGISTRAR					
Howard H. Hubbard, 4107 Wilkens Ave.					21229					DEC 17 1968					
										25b. REGISTRAR'S SIGNATURE					
										f Charles Judge					



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First <b>Ella</b>		Middle <b></b>		Last <b>Meynan</b>		2a. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>68</b>		2b. HOUR <b>4:20 PM</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 18, 1914</b>		6. AGE (In years lost birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Hurt Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				Md.
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2528 Canterbury Rd.-21234</b>		
14. FATHER'S NAME First <b>Samuel</b> Middle <b>Short</b>		15. MOTHER'S MAIDEN NAME First <b>Ella</b> Middle <b>Scruggs</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>220-03-4060</b>		17. INFORMANT <b>Frederick D. Meynan</b>		Address <b>Same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probably brain hemorrhage</b> <b>4319</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>331X</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>1968</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-27-</b> , 19 <b>68</b> , to <b>12-28</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12-28-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Christina Feliciano, M.D.</b>		DEGREE <b></b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/29/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>Christina Feliciano, M.D.</b>		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>								
23a. BURIAL CREMATION, (Specify) <b>Burial</b>		23b. DATE <b>Jan 2, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>				
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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Jan. 1, 1914

Homeville

Elia Forster

220-0-1000 Frederick J. Forster Sam

Samuel Forster

Elia Forster

Jan 2, 1914

Homeville

220-0-1000

Frederick J. Forster

Elia Forster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>John</b>			First <b>John</b> Middle <b>-</b> Last <b>MICHAEL</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>68</b>		2b. HOUR <b>4:05p</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>5-21-14</b>		6. AGE (In years last birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Owings Mills</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rosewood State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Dependent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>128 North Chapel Street</b>	
14. FATHER'S NAME First <b>Unknown</b> Middle <b>-</b> Last <b>-</b>			15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>-</b> Last <b>Michael</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <b>no</b> (If yes give war or dates of service) <b>--</b>			16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Necrotizing orthostatic pneumonia</b> <b>188X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma, bladder</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 6 mon</b> <b>1 yr 6 mon.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1810</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>8</b> Year <b>68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>7/12</b> City or Town <b>12/8</b> County <b>19 68</b> State <b>19 68</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>7/12</b> , 19 <b>20</b> , to <b>12/8</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Richard A. Jones, M.D.</b>					DEGREE <b>M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/10/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Richard A. Jones, M.D.</b>					22e. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Owings Mills, Md.</b>				
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~embalmer's~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17153										17163														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					20. DATE OF DEATH					2b. HOUR									
Thomas					NMN					MICHALOS					12 Month 26/Day 68 Year					9:35 P M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Male			Cau			May 17, 1895			73 YRS.			MONTHS			DAYS									
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
Greece			USA						Baltimore Md.															
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
Towson					Greater Balto. Med. Center					Restaurantier					Self Employed									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER				
Maryland					Baltimore					Towson					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					52 Berkshire Road				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Soterios Michalopoulos					Helen Antonopoulos																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address														
Yes					11703-3307					Steve Micholas, Towson, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Heart Failure																								
4369 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																								
(b) Cerebrovascular accident; RENAL TUMOR?																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
331X																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 11/9, 1968, to 12/26, 1968, that (I) (we) last saw the deceased alive on 12/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
Baur R. Quillan M.D.															12/27/68									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
															6701 N. Charles Street									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					Dec. 30, 1968					Greek Orthodox Cemetery					Woodlawn, Maryland									
24. FUNERAL DIRECTOR ADDRESS															25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE				
John Burns Sons Towson															JAN 2 1969					J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First ANNA	Middle	Lost MILLER	2a. DATE OF DEATH Month Day Year DEC. 4, 1968		10. HOUR P 45 M					
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH November 5, 1890		6. AGE (In years lost birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Supervisor C&P Telephone Co		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2907 Glenmore Ave				
14. FATHER'S NAME First Middle Lost Adam Miller		15. MOTHER'S MAIDEN NAME First Middle Lost Mary A Verges		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No					16b. SOCIAL SECURITY NO. 212-03-6566		17. INFORMANT Mrs Marie A Romoser 2907 Glenmore Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOKALEMIA, AZOTEMIA</u> 273.8 DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2892 DUE TO, OR AS A CONSEQUENCE OF RENAL TUSULAR ACIDOSIS (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ATRIAL FIBRILLATION - PNEUMONIA, SEVERE DEHYDRATION, C.V.A.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 12/3, 1968, to 12/4, 1968, that (I) (we) last saw the deceased alive on 12/4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Enrique A.		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/5/68						
22d. PHYSICIAN'S NAME (Type) DR. A. ENRIQUE		22e. ADDRESS 6701 N. CHARLES ST. BALTO. MD 21204										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/9/68		23c. NAME OF CEMETERY OR CREMATORY Oaklawn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland						
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]						

11154

UNITED STATES DEPARTMENT OF JUSTICE

MEMORANDUM

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

100-100000

[Illegible]

[Illegible]

[Illegible]

[Illegible]

12/2/68

Enclosure 1 - [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
RUSSELL			MONDIE						Month 12 Day 17 Year 68		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR	
MALE			NEGRO		8/7/27			41 YRS.		7:00A M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
BALTIMORE, MD.			U.S.A.					BALTIMORE COUNTY, Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VET. ADM. HOSPITAL			BARTENDER			BAR		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			BALTIMORE		BALTIMORE				226 Chestnut Street		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
MACK			MONDIE						NELLIE MOULTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			(If yes give war and dates of service)		16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
YES			WW II		220-18-8215			CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL											
571.0 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) LAENNEC'S CIRRHOSIS OF LIVER											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
5811											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from 12/8/68, 19__, to 12/17/68, 19__, that (b) (we) last saw the deceased alive on 12/17/68, 19__, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22e. ADDRESS					
RODOLFO G. MIRO, M. D.			12/17/68			VAH FORT HOWARD, MARYLAND					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL			12-20-68		BALTO NATIONAL		BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
MORTEN & DYETTE FUNERAL HOME			DEC 20 1968		21222						
AVONDALE RD. BALTIMORE, MD.											

11165

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

17156  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17166  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>William</b> First <b>Monroe</b> Middle Last			2a. DATE OF DEATH 12 Month 27 Day 1968 Year		2b. HOUR 7:10P
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH 8/31/1885	
6. AGE (In years lost birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Baltimore County</b> Md.					
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Spring Grove State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>laborer</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> 13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Aquasco</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Aquasco, Maryland</b>			
14. FATHER'S NAME First <b>Unknown</b> Middle Last			15. MOTHER'S MAIDEN NAME First <b>Winnie Anne</b> Middle <b>Monroe</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>213-20-8766A</b>		17. INFORMANT Address <b>Chart : SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Upper respiratory infection</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>491X Arteriosclerotic cardiovascular disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1968</b> , to <b>Dec. 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did not) view the body after death.					
22b. SIGNATURE <b>Anthony J. Young, M.D.</b> DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>12-30-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Jan. 4, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Phillips Ch. Cem.</b>	
23d. LOCATION (City or Town) <b>Aquasco P. Geo. Co. Md.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>Martell Adams</b>		ADDRESS <b>Aquasco, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 9 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17157

17167

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<b>33 mos.</b>		<b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FOREST HAVEN Nursing Home</b>		d. STREET ADDRESS <b>314 S. Highland Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>ALFONSO</b> Middle <b>Morcutti</b> Last <b>Morcutti</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>21</b> Year <b>1968</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 4, 1891</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unk</b>		14. MOTHER'S MAIDEN NAME <b>unk</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>113-01-6871</b>	
17. INFORMANT <b>Mrs. Danelon</b>		Address <b>314 S. Highland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULINARY SUSPENSION &amp; PNEUMONITIS</b> <b>185X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC ALCOHOLIC &amp; HEPATITIS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>177X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> , 19 <b>66</b> , to <b>12/21</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/21</b> , 19 <b>68</b> , and that death occurred at <b>11 P</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Phaw</b>		22b. DATE SIGNED <b>12/22/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Phaw</b>		22d. ADDRESS <b>1311 Francis Ave</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/23</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>
24. FUNERAL DIRECTOR <b>G. N. Zinner</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1968</b>	
ADDRESS <b>263 S. Conkling</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Phaw</b>	

11187

EXHIBIT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P M	
Norman Earl Morris					12	27	1968	7	45 P
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
MALE	WHITE		2/26/1903		65 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		Spring Grove State Hosp		Planner		Funerary Conf.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Parkton				Bond Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
George R. Morris					Martha E. Bond				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		203-10-47621		His wife Mrs. Martha Morris, Parkton, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>4201</u> (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic organic brain syndrome</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>8/4/67</u> , 19 <u>67</u> , to <u>12/27</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12/27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>M.A. Lotfyadef, M.O.</u>		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
								22c. DATE SIGNED <u>12-28-68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
MOHAMAD A. LOTFIZADEH		Spring Grove State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		12/30/68		Maryland Line Cemetery		Maryland Line, Balto, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James J. Hartenstein		New Freedom, Pa.		DATE DEC 31 1968		J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17159					17169				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>			c. LENGTH OF STAY IN 1b <u>3 mos. 22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>					d. STREET ADDRESS <u>207 Maple Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH MUMFORD</u>			First Middle Lost		4. DATE OF DEATH <u>12 27 1968</u>		Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7/14/13</u>		9. AGE (In years lost birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Westminister, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Charles Mumfort</u>					14. MOTHER'S MAIDEN NAME <u>Mary Slorpe</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>212-18-4901</u>		17. INFORMANT Address <u>Charles E. Mumfort 10 Queen Gate Rd</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>4129</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE DIABETES</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/4</u> , 19 <u>68</u> , to <u>12/27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>68</u> , and that death occurred at <u>10:00</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>John H. Shaw</u>						22b. DATE SIGNED <u>12/28/68</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Raymond C. Fink Glen Burnie, Md.</u>						25a. REC'D BY REGISTRAR <u>DEC 31 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Catherine</b>			First <b>A.</b> Middle <b>Myers</b> Last			2a. DATE OF DEATH Month <b>12</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>10 P</b> M
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9/11/1890</b>			6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Rosedale</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1323 Spring Avenue</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homekeeping</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rosedale</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>1323 Spring Avenue</b>		
14. FATHER'S NAME First <b>John Bohlen</b> Middle Last				15. MOTHER'S MAIDEN NAME First <b>Elizabeth Hawkins</b> Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212 32 1967</b>		17. INFORMANT Address <b>Marie Walinski 1321 1/2 Spring Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 yrs</b> <b>4 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> , 19 <b>68</b> , to <b>Dec 30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec 30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>G M Baumgardner</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>12/31/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>G M. BAUMGARDNER</b>						22e. ADDRESS <b>Balto 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/2/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Golden Ring Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>				25a. REGD. BY REGISTRAR DATE <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Charles</b>		First <b>E.</b>		Middle <b>Myers</b>		Last		2a. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>11:15</b> p. <b>M</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>July 22, 1896</b>			6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>							
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>painter and paper hanger</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balt</b>		13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1 Cypress Drive</b>					
14. FATHER'S NAME <b>Charles E Myers</b>		First <b>E</b>		Middle <b>Myers</b>		Last		15. MOTHER'S MAIDEN NAME <b>Ida</b>		First <b>Lewis</b>		Middle <b>Lewis</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>485x</b> <b>Bunders pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>upper respiratory infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>thyrox papillomas - tracheostomy</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>491x</b> <b>sinusitis</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>Dec. 20, 1968</b> , to <b>Dec. 25, 1968</b> , that <del>(he)</del> (we) last saw the deceased alive on <b>Dec. 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Rafael H. Marin</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-26-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Rafael H. Marin, M. D.</b>		22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Cemetery Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>							
24. FUNERAL DIRECTOR <b>Sanadcan Funeral Home</b>		ADDRESS <b>Sanadcan Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Jan 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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